

**Current Directions and Initiatives of the
Department of Mental Health, Mental
Retardation and Substance Abuse Services**

**Presentation to the
Hammond Commission on Community Services and
Inpatient Care**

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Current Directions and Initiatives of the Department of Mental Health, Mental Retardation and Substance Abuse Services

- DMHMRSAS welcomes the opportunity to work with the Commission as it develops recommendations for the Governor on how Virginia can improve the delivery of high-quality, publicly funded, mental health, mental retardation, and substance abuse services, as well as identify methods to build a constructive role for the private sector.
- Today, I have been requested to present the current directions and initiatives of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).
- Simply put, the DMHMRSAS is planning to structure its resources, service delivery, administration, financing, and community contracting functions into a managed system of care.
- A publicly managed and implemented system of care includes:

- ❑ Designated populations as identified recipients of services, based on standardized clinical instrumentation indicating severity/degree of disability, functional abilities, and immediacy of need.
- ❑ Identified menu or array of clinical services and supports for each designated population
- ❑ Targeted funding methodologies
- ❑ Defined utilization management and review criteria and integrated admission and discharge policies and procedures between state facilities and community services boards (CSBs)
- ❑ Quality standards of care for community and facility services
- ❑ Provider performance and consumer outcome measures
- ❑ AChoice@ of community and facility providers -- public and private
- ❑ Protection of human rights

- ❑ Accessible consumer appeals mechanisms

- ❑ Creative and efficient standardization
 - ➔ Uniform consumer and service data
 - ➔ Standardized consistent cost accounting

- ❑ Effective dispute resolution mechanisms:
 - ➔ CSB and consumer/families
 - ➔ CSB and private providers
 - ➔ CSB and DMHMRSAS

- The current environment reflects the historic complexity of Virginia's public mental health, mental retardation, and substance abuse services system.

- This complexity is evident in the scope of activities underway through the:
 - ❑ Hammond Commission on Community Services and Inpatient Care

 - ❑ Joint Legislative Subcommittee (HJR 240, now HJR 225)
 - ➔ Implementation of the 112 recommendations in House Document # 77 -- most require DMHMRSAS action

- Continuing study of the feasibility of a Medicaid carve-out, Virginia's external human rights program, and issues surrounding substance abuse and welfare reform

- Community and Facilities Master Plan
 - Draft plan due to the Department September 17
 - Public hearing on draft -- October 13 - 23
 - Final plan due December 1

- Human Rights Regulations
 - Draft available for public comments
 - Public hearings on draft regulations -- October 27-30

- Enhanced CSB Accountability -- House Bill 428
 - Responsibility for discharge planning
 - Clearer relationship between CSBs and local government -- designation of type of CSB
 - Greater involvement and participation of consumers and family members on CSB boards
 - Enhanced and expanded performance contract
 - Dispute resolution mechanisms for consumers and family members

- ❑ Response to consumer and family demand and legal requirements for choice
 - ➔ CSB Care Management Pilot
 - ➔ Dispute resolution mechanism

- ❑ Targeted state facility standardization and strengthened accountability through performance contracts

- ❑ Opportunities for constructive private sector involvement
 - ➔ Role of procurement and competition in publicly financed mental health, mental retardation, and substance abuse services
 - ➔ Community/regional choice of providers of services other than CSBs
 - ➔ Maintenance of local governance, perhaps through innovative regional approaches

- Current DMHMRSAS initiatives focus on two major areas:
 - ❑ State Facility Quality of Care
 - ➔ State Facility Plans of Correction
 - ➔ Facility Standardization Initiative
 - ➔ Discharge Planning/Continuity of Care Initiative

- Planning for a Managed System of Care
 - Role of the Central Office
 - CSB-Central Office Managed System of Care Work Group
 - Performance Contract Development
 - Performance and Outcomes Measurement System Pilot
 - Medicaid Mental Health, Mental Retardation, and Substance Abuse Services

- A summary of these initiatives follows.

State Facility Quality of Care

- *State Facility Plans of Correction*
 - DMHMRSAS has responded to the systemic and individual facility implications of Dr. Geller's analyses and recommendations related to state mental health facilities. A similar process of expert analysis is being conducted for each state mental retardation training center.
 - Using the Geller analysis and recommendations, each state mental health facility followed a standardized methodology. Preliminary plans were completed 7/31/98 and clinical and operational components are now being reviewed. Areas of concentration included:
 - ➔ Evaluation and Diagnosis
 - ➔ Diagnostic Accuracy
 - ➔ Individualized Comprehensive Treatment Plans
 - ✓ treatment planning process
 - ✓ special treatment needs
 - ✓ behavioral treatment plans
 - ✓ monitoring the treatment planning process
 - ✓ staff training on treatment planning

- Psychosocial Rehabilitation and Rehabilitation Programming
- Seclusion/Restraint and Protection from Harm
- Suicide Prevention and Special Supervision
- Medical Care and Medication Practice, Management, and Monitoring
- Emergency Medical Treatment
- Discharge Planning and Community Placement
- Staffing and Staff Training
- Discipline Specific Staffing (Treatment Teams)
- Performance Improvement/Quality Assurance Plan
- Clinical Performance Monitoring
- Risk Management

- As you know, Governor James Gilmore has decided to fund WSH improvements now, thereby putting Virginia ahead of DOJ for the first time since DOJ came to Virginia
- DMHMRSAS has contracted with six mental retardation experts to visit, review and make recommendations for improvements at state training centers
 - Reports are expected by 9/15/98.

○ *Facility Standardization Initiative*

- ❑ The Department has convened a statewide work group comprised of central office professionals, facility directors, human rights staff, and CSB and facility professional staff.
- ❑ This group will develop system-wide mental health and mental retardation facility policy, procedures, and practices on a systemic integrated and standardized methods platform.
- ❑ Draft standardized topic areas will be completed on 10/15/98.
- ❑ The draft standards will be reviewed by a steering committee with consultant assistance.
- ❑ Statewide implementation is scheduled for 7/1/99.
- ❑ There are over 140 professionals participating in this important work. There are 14 individual work groups.
- ❑ Topics for standardization include:
 - ➔ Admissions and Discharges
 - ➔ Active Treatment/Services and Supports
 - ➔ Medical Care
 - ➔ Medication Management

- Behavior Management
- Seclusion and Restraint
- Patient/Resident Leave Practices
- Medical/Clinical Records
- Client Abuse and Neglect
- Risk Management
- Quality Assurance
- Staffing Levels
- Competency Training and Development

○ *Discharge Planning/Continuity of Care Initiative*

- Based on House Bill 428, the significant comments about this topic in Dr. Geller's reports, and consumer and family concerns, the DMHMRSAS convened a statewide work group to address this important system-wide issue.
- The work group is comprised of all 15 facility directors, the 40 CSB executive directors, and central office staff. Consumer and family advocacy groups have been notified of and are welcome at all meetings.
- The statewide group met on May 28 and August 6.

- ❑ DMHMRSAS provided a standardized protocol for state facility and CSB use as a platform for regional plans to assure appropriate and timely discharges
- ❑ Draft regional plans submitted to DMHMRSAS on 7/31/98
- ❑ DMHMRSAS will review and analyze the five regional plans and draft a comprehensive facility discharge policy and protocol (Continuity of Care Standards) by 11/1/98.
- ❑ A small work group will be convened to review the draft policy/protocol between 11/4/98 and 12/31/98.
- ❑ The Continuity of Care Standards will become an element of the draft CSB Performance Contract for FY 2000 and will be available for public comment and review on 1/1/99.
- ❑ These standards will cover:
 - ➔ Prescreening services prior to state facility admission
 - ➔ CSB/facility consumer services planning/coordination
 - ➔ Predischarge planning
 - ➔ Resolution of disagreements about patient/resident's readiness for discharge
 - ➔ Post-discharge linkage with CSB services
 - ➔ Implementation is scheduled for 7/1/99.

Planning for a Managed System of Care

- *Role of the DMHMRSAS Central Office*
 - The structure and resources utilization of the Central Office must also change if the Commonwealth of Virginia is to plan, implement, and benefit from a managed system of care.
 - Consideration is being given to the role, function, and resources capacity of the DMHMRSAS in many areas, with a concentration on:
 - ➔ Internal structure and functions of the DMHMRSAS
 - ➔ Planning
 - ➔ Standardized policies and procedures: individualized treatment
 - ➔ Assistance, monitoring, and accountability
 - ✓ State facilities
 - ✓ CSBs (performance contract; services capacity; and variability of cost)
 - ✓ Private sector
 - ➔ Primary and psychiatric medical care
 - ✓ State facilities
 - ✓ Pre-admission screening
 - ✓ Discharge planning
 - ➔ Human rights
 - ➔ Designated populations for services:

✓ Facilities

✓ CSBs

→ Consumer and family involvement

→ Provider performance and consumer outcome measures

→ Development of an integrated information and data system

→ Quality assurance/risk management

○ *CSB-Central Office Managed System of Care Work Group*

□ Guiding concept is constructing a managed system of care that focuses on service delivery rather than system structure

□ Work group will consider:

→ Designated populations to be served

→ Services and supports benefit packages and costs

→ Community and facility continuity of care, including pre-admission screening and pre-discharge planning

→ Standards of care

→ Utilization management and review

→ Data requirements, including service capacity and consumer flow-through information

→ Provider performance and consumer outcome measures

→ Appeals procedures

→ Dispute resolution processes

- ❑ Small planning group will meet in September to finalize agenda for a two-day meeting of a small representative work group in November.

- *Performance Contract Development*
 - ❑ Revised performance contract is part of systemic pathway to change and improve the service delivery system

 - ❑ DMHMRSAS is moving forward with significant restructuring of the performance contract
 - ➔ DMHMRSAS functions as purchaser of services
 - ➔ Contract identifies in measurable terms who is served and what services are paid for with state-controlled funds

 - ❑ Section 37.1 -198 of the *Code of Virginia* requires DMHMRSAS to make the standard CSB performance contract form proposed for next fiscal year available for public review and comment on January 1 for a period of 60 days.

 - ❑ Process for developing the FY 2000 performance contract will include:

- Focus group of consumers and family members convened in late October or early November to solicit ideas about contract components and changes
 - External group of CSB and private providers, consumers, family members, and other advocacy groups convened in November and December to react to and refine draft contract
- House Bill 428 requires fundamental changes in the performance contract in FY 2001(7/1/2000):
- consumer outcome and satisfaction measures
 - provider performance measures
 - consumer and family member participation and involvement measures
 - state facility bed utilization targets
 - standardized cost accounting and financial management systems approved by DMHMRSAS
- *Performance and Outcomes Measurement System*
- Routine assessment of consumer outcomes, provider performance, consumer satisfaction, consumer and family member involvement
 - Comprehensive set of performance and outcome measures:
 - Adult mental health -- CSB and Inpatient

- Child mental health -- CSB and Inpatient
- Adult substance abuse
- Mental retardation
- Prevention

- Pilot tests of common sets of indicators for performance domains related to effective delivery of publicly-funded services:
 - Access
 - Quality and appropriateness of care
 - Outcomes
 - Human rights
 - Inter-system performance
 - Consumer and family participation

- Pilot timelines
 - MH/SA pilot project will be complete on 3/15/1999, begin statewide implementation on 7/1/1999
 - Prevention pilot project will be complete on 12/1/1999, begin statewide implementation on 12/31/2000
 - MR pilot project will be complete on 10/15/2000, begin statewide implementation on 12/31/2001

- Final pilot evaluation report will be prepared in January 1999
 - Identify strengths and weakness of POMS

- Address overall cost-benefit of POMS
- Recommendations for improvement/next steps

○ *Medicaid Mental Health, Mental Retardation and Substance Abuse Services*

- ❑ Medicaid coverage is a key component of a managed system of care.
- ❑ Starting in 1990, DMHMRSAS and the Department of Medical Assistance Services cooperatively expanded mental health and mental retardation coverage significantly through the State Plan Option and the Mental Retardation Home and Community-Based Waiver.
- ❑ In 1998, coverage was further expanded to include limited substance abuse services for pregnant women and their dependent children.
- ❑ In FY 1998, Medicaid reimbursement (state & FFP) for SPO services exceeded \$ 71.9 million. Total Mental Retardation Home and Community-Based Waiver fees exceeded \$84 million This includes \$ 42 million paid to private providers.

- ❑ Currently, the Mental Retardation Home and Community-based is being revised to make it more flexible and accessible.
- ❑ Finally, the feasibility and desirability of a carve-out of behavioral health care services is being studied by the HJR 225 Joint Subcommittee. Recommendations will be made next year.
- ❑ A matrix of Medicaid facility and community covered mental health, mental retardation, and substance abuse services follows:

Medicaid Covered DMHMRSAS Facility Services

<i>Inpatient Facility Care Services</i>	Facility Type			Reimbursement Method
	MH	MR	Chronic Disease	
Medical-Surgical Care	×	×		Cost Settlement
Skilled Nursing Service	×	×		Cost Settlement
Intermediate Care	×	×		Cost Settlement
Acute Intensive Treatment	×			Cost Settlement
Chronic Disease Care			×	Cost Settlement
Substance Abuse (Detox)	×			Cost Settlement

Medicaid Community Covered DMHMRSAS Services

<i>State Plan Option Services</i>	Disability Area			Unit	Rate
	MH	MR	SA		
Intensive In-Home	×			Hour	\$70.00
Day Treatment (Child/Adolescent)	×			Unit (2-2.9 hours)	\$38.05
Day Treatment, Partial Hospitalization	×			Unit (2-3.9 hours)	\$36.23
Psychosocial Rehabilitation	×			Unit (2-3.9 hours)	\$24.23
Crisis Intervention Rural Urban	×			15 Minutes	\$18.61 \$30.79
Case Management MH MR	×	×		Month Unit	\$208.25 \$175.40
Crisis Stabilization Northern Virginia Rest of State	×			Hour	\$89.00 \$81.00
Support Services Northern Virginia Rest of State	×			Unit (1-2.99 hours)	\$91.00 \$83.00
Intensive Community Treatment Northern Virginia Rest of State	×			Hour	\$158.00 \$144.00
Residential Treatment for Pregnant Women Northern Virginia Rest of State			×	Daily	\$120.00 \$108.00
Day Treatment for Pregnant Women with Dependent Children Northern Virginia Rest of State			×	Unit (2-3.9 hours)	\$60.00 \$54.00
	Disability Area			Unit	Rate

<i>Mental Retardation Home and Community-Based Services</i>	MH	MR	SA		
Congregate Residential Support		×		Hour	\$12.50
In-Home Residential Support		×		Hour	\$12.50
Supported Employment Individual Work Crew		×		Unit (1-3.9 hours)	\$16.00 \$32.50
Day Support Regular (Center/NonCenter) High Intensity (Center/NonCenter)		×		Unit (1-3.9 hours)	\$22.50 \$32.50
Therapeutic Consultation		×		Hour	\$50.00
Environmental Modification Rehab Engineer Structural Supplies/Materials Transportation Modification		×			Actual
Assistive Technology Rehab Engineer Off-Shelf Supply Cost		×			Actual
Personal Assistance Northern Virginia Rest of State		×		Hour	\$11.50 \$ 9.50
Nursing Service RN Northern Virginia RN Rest of State LPN Northern Virginia LPN Rest of State		×		Hour	\$30.00 \$24.70 \$26.00 \$21.45
Respite Care Northern Virginia Rest of State		×		Hour	\$11.00 \$ 9.00

Disability Area

<i>Clinic Services</i>	MH	MR	SA	Reimbursement Rate
Psychiatric Examination	×			Varies depending on provider (M.D. v. Non-M.D), service intensity, and population (child v. adult)
Individual Psychotherapy	×			Varies
Family Psychotherapy	×			Varies
Group Psychotherapy	×			Varies
Medication Management	×			Varies
Injections	×			Varies
Psychological Testing	×			Varies
Assessment Aphasia	×			Varies
Developmental Testing	×			Varies
Neurobehavioral Testing	×			Varies

<i>Early Intervention (Infant and Toddler) Services</i>	Disability Area			Reimbursement Method
	MH	MR	SA	
Physical Therapy		×		Cost Based
Speech Therapy		×		Cost Based
Occupational Therapy		×		Cost Based

- Detailed information on DMHMRSAS actions in response to the Geller Reports, the review of the mental retardation training centers,

and the DMHMRSAS response to the U.S. Department of Justice CRIPA investigations are appended to this presentation.

- I would be pleased to respond to any questions you might have about the DMHMRSAS initiatives outlined in this presentation

- Please note the following appendices:

Appendix A - The Status of Actions Taken in Response to the AGeller Reports@in Virginia Mental Health Institutions.

Appendix B - The Status of Actions to Review Virginia's Mental Retardation Training Centers.

Appendix C - Current Status of the U.S. Department of Justice CRIPA Investigations.

Appendix A

The Status of Actions Taken in Response to the Geller Reports on Virginia's Mental Health Institutions

- We heard from Dr. Jeffrey Geller this morning. The consultation provided by Dr. Geller to the DMHMRSAS focused on:
 - Facility Policies/Procedures
 - Facility Organization Chart
 - Ward Organization and Location
 - Distribution of Staff by Discipline/Activity
 - Patient Records
 - Staff Patterns by Ward/Shift
 - Death Reviews for 12 months, if any
 - Budget/Filled Positions
 - Patients Ready for Discharge
 - Seclusion and Restraint Data
 - Pharmacy, medication with doses by patient
 - Extensive Interviews: staff, patients

- The structure of Dr. Geller's reports included:
 - Data and Findings
 - ➔ Overall assessment
 - ➔ Medical records
 - ➔ Diagnostic accuracy

- Patient assessments
- Treatment planning
- Psychosocial rehabilitation
- Staffing/disciplines
- Integration of psychosocial rehabilitation and staffing
(includes analysis of patient hours per week)
- Seclusion and restraint
- Medication practices (polypharmacy, PRN medications,
dosages)
- General/primary medical care
- Discharge planning and community placement

Recommendations

- Epilogue
- Extensive appendices from hospital records

○ Dr. Geller Identified the Following Systemic Issues

AOne size fits all@(patient needs)

- Lack of interdisciplinary treatment
- Lack of individualized treatment planning

ALearned helplessness@

Blindness to own facility (Athings have been done this way for
years@)

- Insufficient community participation in discharge planning
- Medical records - insufficient thinking in the record
- No ability to control/admissions
- Insufficient community resources
- Unclear Central Office role
- Lack of adequate Central Office direction/oversight (e.g., facility organization; assistance; monitoring; accountability/oversight; differential policies and procedures)
- Too many consumers who don't belong in the hospital
- Staffing deficiencies/over reliance on good will factor
- 15 separate fiefdoms (lack of standard clinical policies)
- Medication issues
- Inefficient use of resources across and within facilities
- Lack of consumer and family participation

- ❑ Inappropriate treatment of primary substance abuse in facilities
- ❑ Management vs. Treatment
- ❑ Training needs
- ❑ Risk Management/Quality Improvement as a clinical tool
- I would sum the Geller Reports in one simple statement: we have heretofore an unmanaged facility/community system of care that has yet to modernize its mission, prioritize its work, modernize treatment practices, standardize policies and procedures, align funding with goals and priorities between facilities and CSBs, and integrate quality with data, training, and accountability.

Appendix B
The Status of Actions to Review Virginia's Mental Retardation
Training Centers

- DMHMRSAS has contracted with six mental retardation experts to visit, review and make recommendations for improvements at Central Virginia Training Center, Southside Virginia Training Center, Southwestern Virginia Training Center, and Southeastern Virginia Training Center.

- Consultant fields of expertise include:
 - Psychiatrist
 - Medical Physician
 - Psychologist
 - Speech Pathologist
 - Occupational Therapist
 - Physical Therapist

- The foundation for standards of care is the level of care at Northern Virginia Training Center, based on the DOJ standards.

- Reports are expected by 9/15/98.

- Individual training center plans of correction and implementation strategies will be developed thereafter.

Appendix C
Current Status of the U.S. Department of Justice CRIPA
Investigations

- On June 3, 1998, the CRIPA lawsuit that had been filed in July 1996 was dismissed with prejudice, meaning that the DMHMRSAS met every one of its obligations under the settlement agreement, and are no longer subject to DOJ jurisdiction at the Northern Virginia Training Center (NVTC).
 - DMHMRSAS is proud of the high quality of services offered to residents of NVTC, and will maintain the same level of services as we did under the settlement agreement
 - Total funding increases for NVTC to achieve and maintain compliance with the agreement were \$4.7 million annually.
- There are currently two facilities under active settlement agreements with DOJ: Eastern State Hospital (ESH) and Northern Virginia Mental Health Institute (NVMHI).
- DOJ will return to ESH in mid-October to conduct the final certification tour. At that time, DOJ will assess whether ESH has substantially complied with the DOJ settlement agreement, filed in July 1996.

- ❑ DMHMRSAS has closely monitored and worked with ESH in the past 2 years, and Dr. Geller has consulted with ESH frequently during this period.
 - ❑ DMHMRSAS does not anticipate any major problems when DOJ visits, because the care and treatment being provided to consumers at ESH has dramatically improved.
 - ❑ If DOJ agrees that ESH is in substantial compliance with the settlement agreement, the ESH lawsuit will be dismissed with prejudice (as was the NVTC lawsuit), hopefully in early 1999.
- Under the NVMHI settlement agreement, the DMHMRSAS must give notice to DOJ that NVMHI is in substantial compliance with the plan of improvement by January 1, 1999. Then, DOJ will return to NVMHI in March or April 1999 to conduct the final certification tour to assess compliance.
- ❑ DMHMRSAS is working closely with NVMHI to monitor progress in implementing the plan of improvement. Our focus presently is on medical care and discharge issues.
 - ❑ DMHMRSAS expects that by January 1999, NVMHI will be in compliance with the Plan. We hope to have the NVMHI lawsuit dismissed with prejudice sometime next summer.

- ❑ Total funding increases for NVMHI to achieve and maintain compliance with the settlement agreement were \$3.1 million annually.
- DMHMRSAS is currently in the last stages of negotiating a plan of improvement with DOJ for Central State Hospital (CSH). DOJ investigated CSH in April 1997, and DMHMRSAS has been working cooperatively with DOJ since that time.
 - ❑ No lawsuit filed to date, but it is expected that a lawsuit will be filed and dismissed simultaneously (as with NVMHI) subject to a settlement agreement that requires substantial compliance with the agreed-upon plan of improvement.
 - ❑ Although there is no final agreement at this time, significant progress has been made at CSH over the past year.
 - ❑ Annual funding has increased by \$10.16 million. This has permitted the DMHMRSAS to:
 - ➔ contract for the Riverside Forensic treatment program, a 35-bed program serving persons transferred from jail for evaluation or emergency treatment;
 - ➔ implement the 36-bed medium security forensic unit;
 - ➔ significantly increase clinical staffing on the maximum security forensic unit and throughout the hospital;
 - ➔ discharge several hard to place consumers;

- ➔ move the adolescent unit to a more secure setting; and
 - ➔ create a special program for forensic patients who are mentally retarded.

- DOJ has notified DMHMRSAS that it will investigate Western State Hospital (WSH) the week of September 14.
 - DMHMRSAS will work cooperatively with the DOJ to negotiate a plan of improvement and has already drafted a plan which includes options involving bed reductions and increased staffing.

- With the systemic improvements described previously, the DMHMRSAS does not anticipate DOJ involvement in any other facilities at this time.