Regional Utilization Management Guidelines

Interim Report

January 2008

submitted by the

Northern Virginia Strategic Planning Partnership

Mental Health Services

Introduction:

In the April 2007 Regional Utilization Management Preliminary Response, the Northern Virginia Strategic Planning Partnership addressed many of the questions pertaining to regional adult mental health services in our area. Because of time constraints, however, some questions were deferred to this January 2008 Interim Report.

Regional programs, regional funding, and regional utilization management are embraced in Northern Virginia. This Interim Report offers the opportunity for HPRII to explain its services, processes, and successes as well as the barriers and issues it faces when providing regional services to adults with mental illness.

Northern Virginia has a long history of making a full range of services available through its five Community Services Boards, the Northern Virginia Mental Health Institute and an array of local psychiatric units in private hospitals. It augments those services with state hospital care for forensic patients at Western State Hospital and for older adults at Eastern State and Piedmont Hospitals. Regional programs and budgets are handled by a central regional management unit that routinely plans, manages, monitors, and evaluates services that are funded for the region by DMHMRSAS. In addition to regional funds, the five CSBs receive direct state and substantial local funding. Services in Northern Virginia are provided by each CSB that actively collaborate with state facilities on a variety of service delivery issues regardless of funding source.

At its February 2008 meeting, the Northern Virginia Strategic Planning Partnership will review and prioritize the open mental health issues. The Mental Health Work Group will then develop a work plan to address these issues and provide recommendations for the Final Regional Utilization Management Report, due January 2009.

Question 1. *What actions does the region take when a consumer needs an inpatient psychiatric bed, no private inpatient bed is available, and the state hospital is at capacity?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Northern Virginians used 324 publicly and privately funded psychiatric beds in Northern Virginia and elsewhere in 2006. Usage is projected to increase to 377 by 2015 (See Attachment A-1 and Attachment A-2). • Review all persons ready or nearly ready for discharge; examples of options include temporary use of Temporary Detention Order (TDO) beds, use beds of person on special hospitalization status, use crisis care as step-down for persons near discharge; collaborate with NVMHI using post-hearing bed services protocol. • Continue to contact hospitals to find recent discharge. • Continue to try to develop supported release, i.e. housing with family if risk can be managed. • Seek beds out of region. • Contact hospitals in Washington, DC and Maryland, if voluntary with insurance. • If TDO, Fairfax sometimes uses medical bed with police guard. • Reassess/reconsider services in Crisis Stabilization program. • Work collaboratively with Special Justice to dismiss from hearing/dismiss court-ordered hospitalization and re-detain. • Telephone consultation with Executive Directors and NVMHI Director.	• Lowest per capita public hospital utilization in state. • Linkages to crisis stabilization prior to hospital admission in order to facilitate step-down to discharge. • Ongoing relationship building with private hospitals. • No recent loss of private beds. • 40% increase in NVMHI admissions during FY 2006. • NVMHI beds available for TDO. • Decreased Length of Stay (LOS) on restructured NVMHI units. • LIPOS average LOS continues to be low, in spite of slight increase in average LOS last year.	• Lack of resources to serve persons with high acuity and high complexity (e.g. medically involved, elderly) at crisis stabilization programs. • Insufficient resources to provide timely access to appropriately intensive diversions and stepdown services (e.g. crisis care) for people presenting with high acuity. • Lack of State funding to cover the increasing cost of purchasing private sector beds. • No increase in the number of State or private hospital psychiatric beds, resulting in occasional non-availability of beds. • Need more staff resources for discharge planning. • Lack of supported affordable housing. • Lack of place to live for homeless people at NVMHI who have no place to go upon discharge. • Lack of incentives for nursing home providers to accept people discharged from NVMHI. • Beds at NVMHI are occupied with persons with long LOS and/or those who could benefit from another level of services (e.g. nursing homes, transitional units for persons on NGRI status).

Question 1 - Continued		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
		• If a person who is dangerous to others is in need of imminent care and if criminal charges are also pending against this person, the only recourse is to allow the criminal process to proceed and recommend further assessment while the person is incarcerated. (This situation occurs infrequently.)
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• Will work on specific recommendations for final report to be submitted in January 2009.

Question 3. *Has the region established a time limit on how long consumers who need beds can wait in local hospital emergency departments, and, if so, what is the time limit?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• No. The wait varies from situation to situation.	• There is no regional time limit for how long people can wait for beds. Though the Emergency Custody Order (ECO) four-hour limit is always present, some jurisdictions have found police and hospitals to be flexible in holding patients until a bed can be located.	• Time limit on ECOs and the level of discretion given to police departments and hospital emergency departments can be a barrier. • The hospital emergency room experience is sometimes detrimental for persons with mental illness or mental retardation. Solutions will be explored through the Private Hospital Workgroup. • No. Va. needs but does not have a facility like Hiram Davis Medical Center. • Skilled nursing care for persons with mental illness or mental retardation is minimal to nonexistent in No. Va.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• Solutions will be explored through the Private Hospital Work Group in 2008.

Question 4. *How does the region handle admissions to state hospitals or training centers after regular working hours or on weekends?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• NVMHI admits persons 24/7. CSB Emergency Services workers contact the NVMHI Nursing Supervisor who collaborates as necessary with the on-site primary care physician and/or the psychiatrist on call. Generally speaking, minimal screening data are requested such as vital signs and breathalyzer. However, based on the presentation and history of the person needing hospitalization, additional information may be requested to assure that the person accesses services in the most appropriate setting, especially if there is an indication that acute medical care could be needed. • NVMHI prioritizes timely community access to beds. Consistent with this commitment, anticipatory planning occurs during regular business hours. This includes accomplishing transfers among units and room changes so that people can be readily admitted as needed after 5 p.m. or on weekends or holidays. Notifications of upcoming discharges occur and beds on hold due to special medical status in our out of NVMHI are reevaluated/released to afford maximum access. Other creative strategies include temporary utilization of beds of people on pass for community re-integration. All of this is done when on-site personnel believe they cannot accept a patient and the CSB indicates no other alternatives. This consultation affords an opportunity for additional dialogue to assure that all creative options have been considered.	• The strength of the regional working relationships and NVMHI's commitment to maximizing bed access has enabled us to avert many potential crises.	

Question 4 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
No additional comments		

Question 5. *What are the region's criteria and processes for admission to state hospitals and training centers, and what are the region's processes for resolving disputes about these admissions? What roles and responsibilities has the region identified for the Department in addressing these issues?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Admission criteria for NVMHI are TDO criteria: danger to self or others and substantially unable to care for self. In addition, patients' medical needs must be consistent with NVMHI's medical capacity, so that persons are admitted to a setting most equipped to meet acute medical/surgical diagnostic or treatment needs. • Developed Levels of Treatment model for psychiatric patients (see Attachment B). • A Preliminary Report was prepared by an MR/MI Work Group in March 2006. This will form the basis for additional work that will take place during 2007. • Disputes are resolved by: o Consultation of sending hospital MD and NVMHI MD o Review of which consumers can wait in sending hospital, conducted by NVMHI Admissions and CSB discharge planners o Collaboration between NVMHI, CSB and sending hospital regarding innovative options, such as transfer to Hiram Davis Medical Center in one instance o NVMHI provides psychiatric consultation to sending hospital.	• Regional discussion of challenging cases/scenarios. • Both the NVMHI Director and Medical Director are available for consultation. • Creation of MR-MI Clinical Response Team (CRT). • Regional work groups, which include DMHMRSAS representation, resolve issues and propose changes. • Protocol has been established for NVTC and NVMHI to facilitate MH/MR consumer care.	• Need to differentiate between role of training center for persons with mental retardation and a psychiatric hospital for persons with mental illness, some of whom also have mental retardation. • Limited regional resources, particularly for MR population, dually diagnosed MR/MI, skilled nursing care or persons on NGRI status. • Systemic challenges as a result of a bifurcated system of care that treats MH and MR as separate entities and presents obstacles for coordinated care. • DMHMRSAS can assist with problem-solving, such as facilitating needed system reform, helping change regulations, etc. • Need clarification of DMHMRSAS roles and responsibilities for persons under 65 years of age who have a progressive and deteriorating organic condition and need nursing care. • Incomplete or inaccurate communication from referring hospitals about persons' acute medical/surgical treatment or diagnostic needs. • Lack of clarity and varying CSB capacity to do basic medical screening.

Question 5 - Continued		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• Department has a collaborative role to help resolve issue. • Provide funding for crisis services instead of using local resources. • Assist with out of state services. • Collaborate with locality in addressing issues of self-advocates.		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• State hospital priority is serving uninsured consumers. • NVMHI admission priority is given to post-hearing, uninsured consumers with further priority given to consumers whose hearing occurred outside a hospital setting. • Additional NVMHI admission priority is given to post-hearing consumers who have behavior issues that a private hospital will not accept.	• Use Level of Treatment system, especially Level I and II to assess appropriateness for public and private hospitalizations.	• Consumers who are not appropriate for a state facility but have no other available options: o Consumers with challenging behaviors but no mental health diagnosis; medically complicated; brain Injury with no psychiatric diagnosis; dementia and early dementia where nursing home is needed; substance abuse problems only where detoxification services are needed. • Referral of insured persons to the State facility either as part of an agreement with the private hospital in order to secure admission for initial treatment. This has implications for CSBs as "gatekeeper." <u>Recommendation:</u> To address incomplete or inaccurate communication from referring hospitals about persons' acute medical/surgical treatment or diagnostic needs, should consider standardizing processes with other systems (such as Sheriffs office). o Differentiate between the more abbreviated medical screening and ER clearance that may be indicated based on screening "triggers." • Consider using a standard ER form.

Question 6. *How does the region connect admissions to and discharges from (front and back doors) its state hospital and its training center in its regional utilization management processes or activities?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• No. Va. uses several regional work groups to resolve issues. (See Attachment C) • Emergency managers and aftercare managers from all of the regional CSBs, NVMHI and a DMHMRSAS representative meet monthly to review admissions, discharges, use of LIPOS and RDAP funds. UM data is collected and reviewed at that meeting. DAD Steering Committee comprising Executive Directors from five CSBs and NVMHI Director reviews trend analyses and makes recommendations accordingly. • No. Va. has lowest per capita utilization of public psychiatric beds in Virginia that may reflect efficient use of State inpatient/training center resources or may reflect limited resources and hidden unmet needs.	• No. Va. has lowest per capita utilization of state facilities in Va. • Compliance with state discharge protocols. • Frequent active review of Extraordinary Barrier List (EBL) and identification of needed resources.	• Inadequate State funding to establish a comprehensive data system of care for executive level planning and for staff to review clinical information. • NGRI population that requires different criteria for discharge. • Inadequate incentives to facilitate admission to nursing homes for persons under age 65 who have progressively deteriorating organic process or those who need skilled nursing care. • From consumer perspective, concerns about what happens to consumer after he leaves the hospital: o where he will live and get medical care o may lack psychotropics or resources to arrange for psychiatric appointments o needs help with transition from hospital to community. • Need an array of services to prevent admissions to hospitals and to facilitate discharges.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• CSB specific discharge planning with collaboration among discharge planners, Emergency Services Managers, Aftercare Coordinators, Regional Projects. • Monitoring of RDAP (Regional Discharge Assistance Project) plans, advocacy for additional resources to maintain consumer in services and housing and prevent re-hospitalization.	• Nursing home services for young adults with severe physical disabilities, persons under 65 who need skilled nursing care, and geriatric consumers with mental health issues are difficult to access.

Question 6 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• Triage acute care admission through LIPOS hospitals with State discharge planning support at time of admission and a focus on direct discharge from LIPOS hospital. • Developing Peer-to-Peer Bridge Program for patients leaving NVMHI. • Established RAFT program for older adults. • Review of ready for discharge and EBL (Extraordinary Barriers List) data to discuss and identify barriers to discharge patterns for consumers in State Hospital.	• Lack of an integrated database that supports trend analysis. • Consumers with sexual offense issues, fire setting, and aggressive behaviors require development of specialized services; services do not currently exist in the region. • Housing resources, both group residences and supported living services, are limited. Additionally there are no real transitional programs that provide case management services to connect consumers with supports and entitlements. Out of area services are less than ideal, moving consumer away from natural supports. • Consumers need help with transition from hospital to community -- typically need help with increased supports, skill development. Recommendation: Need integrated effort to address medical co-morbidities.

Question 7. *How does the region manage and coordinate State facility and community services for the following populations: individuals with co-occurring mental illness and mental retardation, mental retardation with serious behavior crises, co-occurring mental illnesses and substance use disorders, and substance use disorders, in accordance with State Board Policy 1015 Services for Individuals with Co-Occurring Disorders?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Deferred to January 2008 Report		• Too many competing initiatives without sufficient resources or coordination by DMHMRSAS.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• The MR/MH Clinical Response Team (CRT) services were initiated in January 2007. During 2007, 31 persons have been served by the CRT: o 9 received crisis prevention services o 6 received crisis stabilization services o 7 were diverted from hospitalization o 9 received intervention services while they were hospitalized. o Estimate that 475 fewer hospital days were used because of the work of the CRT. • NVMHI and NVTC have a work group that is reviewing workforce training and service enhancements. • NVMHI has added SA counselor on staff. • Alexandria and Fairfax have detox centers and detox diversion programs from hospital and jail. • MI/SA: If need hospitalization, use LIPOS bed or CSU. • Integrated MH/SA CSB services with access to limited MH/SA residential treatment.	• Need additional crisis response capability. • Consumers with intellectual disabilities who also have psychiatric issues (not behavioral) have no option other than hospital at this time if CRT is unable to manage in community. Difficult to state at times if behavioral issues due to "behavior" or psychiatric decompensation. CRT does not have the capacity at this time to do daily intervention and may need hospital to stabilize. Once stabilized, discharge is not timely due to the lack of transitional units or community-based services. • Consumers with intellectual disabilities who also have behavioral issues may be inappropriately placed on a psychiatric unit in a hospital. Recommendation: Consumers with intellectual disabilities and no Axis I diagnosis need access to short term behaviorally focused, 24 hour setting. Recommendation: Review Northern Virginia Regional Mental Health/Mental Retardation Work Group Report of March 2006. • Persons who are substance abusers and need detoxification are inappropriate for NVMHI admission.

Question 7 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• NVMHI and CSBs established a VASIP work group to help address needs of individuals with co-occurring disorders (MI/SA). NVMHI and CSB programs are utilizing Motivational Interviewing and other evidence-based models that recognize and address stages of recovery.	

Question 8. *How does the region ensure that its regional utilization management teams have the ability and capacity to address the unique circumstances and specialized needs of other specialized populations, including older adults and consumers with a forensic status?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Older adults: Public psychiatric hospitalization is not available for older adults in No. Va. Instead, older adults are currently hospitalized at Eastern State Hospital (ESH), 2½ hours away from No. Va. In the near future, all older adults from No. Va. will be hospitalized at Piedmont Hospital instead of ESH. Piedmont is also approximately 2½ hours away from No. Va. On average, No. Va. has 40 people at any given time at ESH. Also, on average, 22 people have been admitted to ESH from Region II for each of the past four years. Fifty-six percent of the people at ESH were, on average, there for less than six months. This speaks to the need to have a short-term facility(s) in No. Va. dedicated to serving older adults experiencing a psychiatric crisis. It also is clear that there are Northern Virginians who will require a long-term specialized mental health facility(s) in order to best meet their needs. • Forensics: Regional forensic group meets quarterly at NVMHI with Kathleen Sadler (DMHMRSAS Forensic Office) as Chair to review forensic issues, including issues involving Competency to Stand Trial, NGRI, jail transfers, forensic admissions to Central State Hospital (CSH) and Western State Hospital (WSH). The 5 No. Va. CSBs have recently hired forensic discharge planners and will be looking at their role and developing some utilization reviews.	• Region has developed detailed plans to address the needs of older adults. The cost of the proposed pilot project is $2,370,000. • No. Va. has been awarded $500,000 from the Virginia General Assembly as of July 1, 2007 (FY 2008) for the Northern Virginia Geriatric Pilot program. In addition, $550,000 has been allocated from the ESH "Transformation" appropriation to Region II to support further enhancement of the initial project of $500,000. Region II now has a total of $1,050,000 for a geropsych pilot to serve older adults. This pilot will decrease the use of ESH by bringing current ESH consumers back to No. Va. and placing them in either a nursing home or an Assisted Living Facility depending on their level of need. • Persons on NGRI status have successfully used crisis care beds to exercise 48-hour privileges to demonstrate readiness for community reintegration.	• HPR II has concerns about adequacy of future forensic capacity at WSH. • Lack of Department approval to divert to WSH those NGRI patients who are not ready for community integration prevents NVMHI from using all of its beds for persons who are ready to return to the community. • Varying levels of acceptance for risk by Forensic Review Panel (FRP) and communities. • Need to review FRP composition and policies to identify opportunities to align with recovery principles. • Significant stigma for persons with mental illness who also have judicial involvement.

Question 8 - Continued		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• Next month, HPR II will meet with HPR I regarding a joint review of WSH forensic issues. HPR II has proposed that NGRI acquittees go from CSH to WSH, rather than to NVMHI, because these acquittees spend years at NVMHI before they are ready for the community.		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Each CSB has a designated forensic discharge planner to work with forensic clients at the hospital, jail and in the community. • A recent statewide study indicated that approximately 16% of the persons incarcerated in state prisons and local jails in Virginia have serious mental illness.	• HPR II participated with HPR I on the redesign of Western State Hospital's forensic unit.	• Older adults: Insufficient number of appropriate beds in Northern Virginia. Piedmont is 3 hours away and private hospitals hesitate to take older adults because of service issues. • Forensics: Delays in reactivating benefits after incarceration; therefore, cannot fund support services. • Forensic/NGRI: Lack of service options for NGRI consumers, including vocational services as well as housing and supervision consistent with community risk tolerance. • Forensic: Lack access to funding to facilitate discharge plans for indigent consumers hospitalized while in jail and returned to jail to resolve legal issues. Chronic pattern of incarceration and hospitalization due to homelessness and lack of resources in the community. • Lack of on-going funding source for services for consumers with head injury issues. • Remaining up to date on the activities and plans of the parallel workgroups can be challenging.

Question 8 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• Undocumented persons have difficulty accessing services. • Lack of available resources to access translators, to provide culturally competent services, and to hire multi-cultural staff, especially those who speak Spanish. • No coordinated effort at the state level to address implications of rising physical co-morbidities among people with serious mental illness. • Lack of access to skilled nursing care for persons under 65. Recommendation: Explore need for additional resources for culturally relevant service delivery Recommendation: Advocate for services for incarcerated persons.

Question 9. *What roles and responsibilities have the State facilities and CSBs identified and agreed upon for the State facilities in the region and how do they support fulfillment of those roles and responsibilities?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
Deferred to January 2008 Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Roles and responsibilities are defined by LIPOS agreements, TDO procedures, bed-finding procedures, Level I/II procedures. • State hospitals are safety nets, as they take consumers with no other resources. • Roles are supported through Discharge protocols for State Facilities and CSBs as well as Continuity of Care Agreement between CSB and State Psychiatric Facilities.	• Discharge protocols for state facilities and CSBs. • Continuity of Care agreement between CSB and state psychiatric facilities. • Established and implemented Levels of Treatment model that focuses on using NVMHI for Levels 2, 3 and 4 (for persons on NGRI status).	• Decisions about role and responsibility are stretched by necessity, e.g., loss of alternative options, refusal by alternatives, etc. • NVMHI beds are not being utilized consistent with the Level of Treatment model because of lack of services for persons needing skilled nursing care/nursing home care and those on the EBL.

Question 10. *How does the region discuss and attempt to resolve utilization management conflicts or raise problems to the region's leadership? What are the Department's roles and responsibilities in these areas?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• The region's DAD UM Coordinating Committee has established guidelines for the region and each CSB to follow. The Committee meets regularly to monitor the status of the regional system. • CSB Executive Directors and NVMHI Facility Director conduct weekly conference calls and meet at least monthly. • Dispute resolution and problem identification occur at: o DAD UM Committee meetings o Weekly conference call of five No. Va. CSB Executive Directors and NVMHI Facility Director o NVMHI UM meeting o Review of EBL guidelines/procedures that guide discharge planning.	• Regional discussions to coordinate discharges are held weekly. • Discussion to resolve the "front door" and "back door" issues are held monthly. • Hired first full-time regional Project Manager.	• In order to use RDAP funds, CSBs must try every other resource first, a process that is very time consuming o DMHMRSAS should eliminate limitations on using Medicaid funding for persons receiving RDAP funds o The Department should be an advocate for these issues. • Lack of supported affordable housing. • Need regional data system. • The Department must allow sufficient flexibility for regions to develop effective UM models that take into account regional characteristics. The Department's focus should be outcome-oriented rather than process-oriented.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• The Regional Manager meets regularly with CSB Executive Directors and the Director of NVMHI to report on status of and issues related to regional programs. • Regional workgroups, trouble shooting by specific CSB staff on behalf of the region, collaboration between facility and CSB staff. • Regional Aftercare Managers, Regional Manager, ES Managers and State facility staff meet monthly to review and discuss regional issues.	• Review EBL regularly for opportunities to discharge patients from NVMHI. • NVMHI Medical Director actively consults with CSB and private hospital staff to provide guidance when persons present with complex medical or psychiatric needs. • NVMHI has fully implemented a low threshold "medical screening" (versus clearance) that conserves hospital and community resources unless certain "triggers" are apparent.	• Need data system to manage and monitor programs. • Need to assure that patients discharged from public psychiatric hospitals receive a non-emergency service appointment at the CSB within 7 days.

Question 10 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Regional Manager attends NVMHI Monthly Utilization Management Meeting and Western State Hospital Utilization Management Meetings on a quarterly basis in order to review current data regarding 30 day readmissions and represent the region as applicable. • NVMHI initiates pre-admission team meetings and clinical case consultations when persons seek readmission within 30 days of discharge. • CSB also completes Safety and Support Plans for patients being discharged from the state hospital that promote awareness of consumer's individualized needs in the community and foster collaboration among all providers that the individual has in their support system.		

Question 11. *How does the region use its regional utilization management processes or activities to ensure that consumers are served in the least intrusive and most appropriate settings and as close to their homes as possible, for instance, so that consumers are admitted to local psychiatric inpatient beds or crisis stabilization beds before they are admitted to state hospital beds, unless compelling clinical needs or circumstances or the unavailability of these community alternatives warrant direct admission to state hospital beds? Also, how does the region use its regional utilization management processes or activities to ensure that consumers who no longer need acute care services do not remain in those settings?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Treatment providers match consumer to appropriate level of care, starting with outpatient services and continuing to crisis beds and finally hospital treatment. • Emergency staff completes DAD UM form for each LIPOS hospital and crisis care admission, where they document the need for that level of care. • Aftercare staff reviews the need for LIPOS inpatient care after five days and after eight days. • MH Manager/Director reviews consumers who need LPOS care for more than 11 days. • Executive Directors review consumers who need LIPOS care for more than 21 days. • NVMHI reviews consumers for whether they meet criteria for active treatment; consumers who are not certified are reviewed by MD and Medical Director and CSB is notified; PTM meetings are scheduled for consumers who have discharge issues. • DAD UM Committee looks at trends, consumers needing re-admission, and consumers needing more than 21 days inpatient care to identify problems and needs.	• Lowest per capita public utilization in Virginia. • Regional work groups (e.g. DAD/RDAP, Emergency Services, Aftercare) regularly review, discuss and solve problems pertaining to consumer and system issues by proposing diversion and/or discharge options, resource development and procedural efficiencies. • Meds adjustments can occur at CSU. • Longstanding regional DAD/DAP/RDAP group has implemented census reduction process and outcomes; development of regional services, e.g., ICRTs; regional collaboration among CSBs and facilities yields ongoing consultation re resources.	• Additional State funding is required for case management services. • Local capacity does not yet exist for older adult population. • Absence of adequate availability of services at all levels of care. • Lack of affordable supported housing. • Need more crisis stabilization beds and PACT teams. • Sometimes patients are admitted to psychiatric hospitals in order to adjust medications. Need to adjust meds in community in order to avoid hospitalization.

Question 11 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Consumers who meet admission criteria for CSUs are referred there instead of psychiatric hospital. Level I consumers admitted to private LIPOS hospital; Level II consumers admitted to NVMHI if bed is available. UR forms are completed and reviewed to assure appropriate service. LIPOS consumers are reviewed each 3 days (by CSB discharge planners) for appropriateness of continued treatment in that setting. • The Regional office is monitoring processes to track admissions, discharges and LOS for LIPOS, CSU and NVMHI to ensure maximal use of hospitalization with minimal LOS.	• Utilize Crisis Care Stabilization to help step-down patients from local community hospital or from state hospital. • Lowest per capita usage of public psychiatric hospitals.	• Need more intensive ICRTs. • In some circumstances (such as fragile NGRI or major adjustment in medication regimen), inpatient med adjustment is necessary. • Need in-home supports for persons who do not receive Medicaid.

Question 12. *How do the region's utilization management processes or activities facilitate and expedite discharges of consumers in state hospitals who were adjudicated and admitted as not guilty by reason of insanity as soon as their discharges are clinically appropriate and legally possible?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
	• Using Crisis Stabilization program for NGRI patients who are on 48-hour passes as part of their community reintegration process.	• DMHMRSAS has not approved HPR II request to transfer to NVMHI only those persons in NGRI status who have unescorted community privileges and transfer to WSH those persons in NGRI status who do not have community privileges. • State Code does not permit establishment of secure facility in community for NGRI outside of a hospital. • Varying levels of acceptance for risk by Forensic Review Panel (FRP) and communities. • Need to review FRP composition and policies to identify opportunities to align with recovery principles. • Significant stigma for persons with mental illness who also have judicial involvement.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Regional efforts as noted above, also including quarterly forensic meetings to inform, problem solve, etc.	• Use CSU (crisis stabilization unit) for step-down for NGRI patients. • Community reintegration with appropriate privileges allows patients with NGRI status to participate in a variety of activities to assess readiness for discharge. • Persons on NGRI status can participate in Work Adjustment Training offered at NVMHI through Recovery Funds.	• Lack of resources to develop a regional program to address this targeted population is a barrier to community services and housing (i.e. history of fire setting, violent, aggressive behavior, chronic psychosis, sexual offense behavior). • Need to work with FRP, judges, attorneys and the community as a whole to determine acceptable levels of risk. Many discharges pending due to requirements to minimize ALL level of risk.

Question 12 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Discharge planners work collaboratively with consumer, inpatient treatment team and support network to develop and implement a community re- entry plan as the consumer progresses through the NGRI process. Community based resources are coordinated and accessed as privilege level allows and based on availability. RDAP NGRI funding is accessed as appropriate to facilitate this process. Finding services for NGRI consumers with complex needs is difficult. • NVMHI IFPC reviews all patients who have not submitted a request for increase in privileging levels in greater than 90 days on a quarterly basis.		

Question 13. *When and how does the region involve the private sector, especially local hospital emergency departments and psychiatric units and private providers of community mental retardation services, in its regional utilization management processes or activities?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
	• A Private Psychiatric Hospitals Work Group meets periodically to address common regional issues. • Each CSB meets periodically with representatives from the private psychiatric hospitals serving its area. • The Regional Partnership and the Health Systems Agency of No. Va. have collaborated on the development of a projected need for inpatient psychiatric beds (see Attachment A-1 and Attachment A-2). • The CSB Executive Directors and the Director of NVMHI have met with the following groups to review the utilization of psychiatric beds: No. Va. Regional Commission (consisting of elected officials), the Chief Executive Officers of the jurisdictions and the Chief Executives of the hospital corporations.	
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
No additional comments		

Question 14. *When and how does the region involve consumers, family members, law enforcement, and the criminal justice system in its regional utilization management processes or activities?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• See Attachment C	• Consumers and family members participate in the No. Va. Strategic Planning Partnership. • Each CSB participates in a Community Criminal Justice Board which meets to review issues associated with TDOs and commitments. • Fairfax, Arlington and Prince William counties have a version of a TDO Task Force which meets regularly. Participants include judges, magistrates, attorneys, independent evaluators, petitioners, hospital representatives, NAMI-No. Va, Office of the Sheriff, police and MH staff. • Jail Diversion project in Fairfax offers alternatives to incarceration.	• Lack of peer specialists.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• CSBs and NVMHI participate in a number of activities that involve consumers, family members, law enforcement and criminal justices, such as: o NVMHI Regional Community Support Center (RSCS) o Recovery contracts that include grants for consumer-run programs o Fairfax CSB Jail diversion Stake Holder Group Meeting (Criminal Justice Law Enforcement) o Fairfax CSB Recovery Work Group Monthly Meeting (CSB staff, family members and consumers) o Fairfax CSB Temporary Detention Stake Holder Monthly Meeting (Criminal justice, law enforcement)	

Question 14 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	o Alexandria CSB Temporary Detention Stake holders Quarterly Meeting (criminal justice, law enforcement, CSB staff, INOVA Mt. Vernon Hospital administrative and clinical staff, magistrate) o Development of Peer Specialists Positions (PACT/Crisis Care Woodburn Place) o NVMHI has an Advisory Council that meets monthly and has representation from families, community advocacy groups, CSBs and current service recipients. o NVMHI RSCS has scheduled training for Fairfax County Adult Detention Center staff. o NVMHI began first NAMI Peer-to-Peer nine-week group on December 7, 2007 with nine consumers. o In conjunction with a consumer-run program, NVMHI also is beginning a Peer-Bridger group for patients from Prince William and Loudoun Counties to provide transitional support for community reintegration. o NVMHI has a Multi-Family support group and also hosts Family Day each May with support from the NVMHI Advisory Council. o Arlington and Prince William CSBs have civil commitment work groups, including CSB, hospital, law enforcement, sheriff, special justice, defense attorney,	

Question 15. *How does the region address inter-regional utilization management issues, such as admissions to state hospitals or local psychiatric inpatient programs, crisis stabilization programs, or training centers from outside the region, with other regions? What are the dynamics of the movement of consumers into and out of the region? How easily are representatives from other affected regions able to participate with the region in discussions about these issues? What roles and responsibilities has the region identified for the Department in addressing these issues?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• WSH – a representative from WSH actively participates in virtually all regional meetings and routinely submits utilization data. HPR II actively participated in the WSH work group responsible for planning the role and functions of a replacement for the existing facility. • ESH – representatives from HPR II have attended all planning meetings regarding the replacement of ESH. Each CSB addresses clinical issues through its assigned clinical liaison. An enhanced process is being established with Piedmont Hospital. • Private inpatient hospitals – all private psychiatric hospitals that are regularly used by HPR II have been invited to participate in regional meetings. • Virtually all persons admitted to psychiatric beds outside of HPR II return to No. Va. at the time of discharge and are actively case managed by CSBs in No. Va.	• DMHMRSAS has allocated $550,000 to HPR II from the funds for community services related to the downsizing of ESH. • Very few admissions per year from No. Va. to training centers outside of No. Va. in the last 10 years. • Funds from WSH are being used for forensic discharge planners at each CSB. • $500,000 from General Assembly for older adults pilot project.	• DMHMRSAS must establish and provide equitable access to specialized services provided in State facilities, such as medical, skilled nursing, TBI, behavioral, employment and skill training for NGRI, etc. • No. Va. faces multiple work force issues, including inability to pay competitive wages. In addition, the work force is faced with high cost of housing and transportation. • In light of the variance in acceptance of risk as well as the stigma for persons on NGRI status, protocols may need to be more detailed when persons are admitted to a hospital in one region but will be discharged to another.

Question 15 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• Monthly meetings for Utilization Management, Emergency Services, Aftercare, and Executive Directors/Directors of NVMHI and NVTC produce good communication among five CSBs and state facilities. • Data shared at regional level. • Other regions are able to join our regional discussions; HPR I has joined Forensic discussion, Piedmont has participated in regional discussions. • Discharge planners work collaboratively with hospitals. • Coordination between responsible CSB and treatment teams to coordinate services and movement. • Hold commitment hearings here for other regions.	• Heavy work load. • Work force issues. • Some services are not Medicaid billable. • Transportation is a critical issue.

Question 16. *How does the region communicate and implement its regional utilization management processes or activities to and with all stakeholders in the region?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• Regional Partnership was established in 2002 consisting of stakeholders from throughout No. Va. It meets on a bimonthly basis. In addition, other committees and work groups have been formed to carry out the work of the Partnership. (See Appendix D)	• Established first regional planning process in the Commonwealth.	
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• Hired regional manager, senior clinician and administrative assistant to support Regional Utilization Management.	• Need a regional database. • Difficult to establish a regional legal entity.

Question 17. *How do the region's utilization management processes or activities support the principle of public management of public resources for effective and responsible stewardship of scarce public funds and the achievement consumer-focused public policy goals? This principle is embodied in the single point of entry role of CSBs and their provision of case management services, articulated in STATE BOARD POLICY 1035 Single Point of Entry and Case Management Services.*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Deferred to January 2008 Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
•	• Strong principles for DAD and DAP activities. • Use NVMHI to make maximum use of vacant beds. • Routinely review RDAP consumers. • Use CSU before hospitalization. • Linking consumers with all eligible benefits to offset cost of services needed for community service, e.g., alternative payers include Medicaid for CRT. • Consumer focus on vocational support to promote financial self-sufficiency. • Partnership with consumers that incorporate consumer contribution to RDAP service funding.	• RDAP funding resources are the funding of last resort. Limited RDAP dollars. • Lack of RDAP funding and policy to allow for cost of living increase for existing providers managing consumers in RDAP funded community service. • Regional Projects were developed to maximize funding resources and to meet complex clinical needs of consumers. Lack of RDAP fund to replicate successful service model. • Consumer funding limited (SSI disability payment; no income for illegal immigrant). • Lack of regional step-down options for consumers ready for less intensive community services.

Question 18. *How do the region's utilization management processes and activities support the realization of the vision in State Board Policy 1036; promote and enhance choices for consumers among service alternatives that most effectively meet their needs, as determined by consumers and their service providers; and focus on addressing the particular needs of each consumer in the most appropriate manner clinically, rather than focusing only on locating available state or community inpatient facility beds?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Deferred to January 2008 Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Most appropriate is usually within the range of available resources, because of stewardship factors (costs), the competing needs of other consumers (triage), social and political issues (perceived risk), regulatory restrictions (licensing and reimbursement), etc. • Consumer preference is considered in the process of identifying and locating the most appropriate clinical option for the consumer. Initial effort focuses on adhering to consumer preference for clinically appropriate services. When all viable options are explored and efforts are unsuccessful in meeting the consumers' preference the effort then focuses on clinical need and availability.	• New Preadmission Screening Form has section to document consumer input, choice. • Clinician reviews all options; consumer can reject options unless most restrictive options are needed (such as TDO). • Discharge plan documents consumer preferences, service availability and reason for lack of service option. • Actively support and fund Recovery projects.	• Lack of funding resources to develop regional service resources within HPRII (i.e.: ALF, SRO, Green House Geriatric Facility etc). • Insurance restricts choice. • Court Mandated Admissions (CMA) restrict choice: Have to go with bed availability. • Lack of a variety and range of community resources limits consumer choice in areas of housing, supports, and day programs. Consumers must accept less than desirable service options as these are the only options available. • Recommendation: Honor crisis plans and advance directives, whenever possible, when developing Individual Service Plans (ISP).

Question 19. *How do the region's utilization management processes or activities comply with data reporting and other requirements in the current Community Services Performance Contract, and how are they consistent with the regional program model(s) in Exhibit J of the contract selected by the region?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• All CSBs will be in full compliance with this requirement no later than June 2007.		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• Northern Virginia has executed an MOA among its five CSBs, Northern Virginia Mental Health Institute and Western State Hospital for its regional programs. Through this arrangement, it is in compliance with the data reporting and other requirements in the Community Services Performance Contract and, in particular, with Exhibit J.	

Question 20. *How does the region measure, monitor, evaluate, and manage the success of its regional utilization management processes or activities, as defined by the first three conditions in the Definition of Success on page 4, including the effects of those processes or activities on private providers in the region?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Explanation and a proposal for measuring outcomes will be provided in Interim Status Report in Jan. 2008.		• Inadequate State funding to establish a comprehensive data system or for staff to review clinical information
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Condition 1: Inpatient psychiatric hospital beds are available within a reasonable time for individuals in crisis who cannot be diverted to less intensively structured alternatives, such as crisis intervention or stabilization services, and who need these beds.	• For several years, Northern Virginia mental health emergency service directors and aftercare directors have met monthly to measure, monitor, evaluate and manage utilization of regional mental health programs. • Inpatient psychiatric beds are usually available immediately with LIPOS funding. • Northern Virginia CSBs participated in the June 2007 study of CSB Face-to-Face Adult Crisis Contact Civil Evaluations and will be used as the CSBs develop an outcome measurement system for regional programs. • The RAFT (Regional Older Adult Facilitation Team) is being implemented to discharge patients from Eastern State and Piedmont Hospitals and to divert older adults from psychiatric hospitals. The recently hired program director is negotiating a contract to provide community beds for older adults. • NVMHI and CSBs jointly review EBL.	• A regional database that will facilitate utilization management of regional programs is under development but is not currently operational. • A two-phased approach to developing outcomes measurements for regional programs is planned for initial implementation in July 2008: o Phase 1: Outcomes to apply to CSBs and NVMHI will be developed by June 2008 and implemented by July 2008. o Phase 2: Outcomes to apply to private hospitals will be developed in FY2009 with a target implementation of July 2009. • Most older adults have Medicare or other insurance, making them ineligible for LIPOS funding. Sometimes private hospitals will not admit older adults with complex services for older adults in a private or state hospital outside of Northern Virginia. However, through the RAFT program, some older adults will be diverted from hospitalization.

Question 20 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Condition 2: Intermediate care facility (ICF/MR) beds are available in training centers or the community within a reasonable time for individuals who need this service setting and choose it instead of less intensively structured or specialized alternatives, such as MR waiver services, and emergency or respite admissions are available at training centers for individuals in crisis who need them.	• Please refer to Interim Report for Mental Retardation Services.	
• Condition 3. State hospitals and training centers do not exceed their operational bed capacities (census).	• The Northern Virginia Mental Health Institute does not exceed its operational bed capacity.	

Mental Retardation Services

Introduction:

In April 2007, the Northern Virginia Strategic Planning Partnership submitted its Preliminary Regional Utilization Management Report to the Department of Mental Health, Mental Retardation and Substance Abuse Services. The RUM Guidance is comprised of 20 questions, 12 of which pertain to Mental Retardation Services. Because of time constraints, however, responses to some of the questions were deferred to the January 2008 Report and all 12 of the mental retardation questions are addressed in this Report.

Mental Retardation services in Northern Virginia are offered in the community and at the Northern Virginia Training Center (NVTC). As noted in the recent Report of the Study of the Mental Retardation Services System in Virginia, the Mental Retardation System is

> "three-pronged and directs:
> The greatest per person financial resources toward those residing in the state's publicly funded facilities (state training centers) where most residents possess intensive medical or behavioral challenges
> Fewer per person resources toward those receiving funding through the MR Waiver; and
> Little or no resources toward those community residents waiting or ineligible for Medicaid or the Waiver. (p. 4)"

Consumer services are funded through a variety of sources, including local, state and Medicaid funds. However, unlike mental health services, there is minimal state funding for regional mental retardation services. On the contrary, Medicaid Waivers are awarded to an individual who is encouraged to exercise freedom of choice in service providers and locations. As a result, Regional Utilization Management of regional funds for regional programs does not occur nor is regional management of Waiver slots possible. Instead, CSBs and NVTC meet regularly to address common issues but do not manage regional funds.

In order to gather different points of view on the RUM Guidelines, a meeting was held on December 14, 2007, with representatives from the CSBs, NVTC, Northern Virginia ARC, Parents and Associates of NVTC, and private vendors. Their points of view are reflected in this document.

Question 2. *Similarly, what actions does the region take when a consumer needs a training center bed, no community ICF/MR bed or MR Waiver slot is available, and the training center is at capacity?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• CSB informs NVTC of situation. CSB does case management. As a last resort NVTC, in cooperation with the CSB, attempts to find a bed in another training center. • NVTC, in cooperation with the CSB, will call Office of MR to seek available MR Waiver slot. • Acknowledges that training center placement is not interchangeable with Medicaid Waiver. • Person may be detained and admitted to NVMHI. • NVTC may refer to another training center, although the other training center may not have an open bed either. • Other training centers may be contacted because NVTC does not have skilled nursing beds.	• NVTC provides respite services. • Very few persons have been admitted to training centers in the last decade. • If NVTC has an unassigned Waiver slot, a consumer who needs an emergency placement may use it. • Establishment of MR/MI clinical response team. • Timely collaboration among CSB, NVTC and NVMHI when person has been admitted to NVMHI.	• Appropriate local community services may not be available for training center residents when a training center indicates that a consumer is ready for discharge. • Locality has need for start-up funds for new services for consumers who have complex needs. • Must sometimes use short-term emergency respite until long-term placement is available. • ICF requires parental consent. • No direct admissions from community to the Hiram Davis Medical Center; a consumer must be admitted to NVTC and transferred to Hiram Davis. • Training Centers do not have an allocation of Waiver slots to serve persons ready for discharge.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• With a growing population, the need for sufficient facility- and community-based services will be determined in 2008. • Parents and Associates of NVTC challenge the concept that low admission rates to NVTC is a success. Instead, they define true freedom of choice by having more facility beds available for those who want them.

Question 3. *Has the region established a time limit on how long consumers who need beds can wait in local hospital emergency departments, and, if so, what is the time limit?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
		• The hospital emergency room experience is sometimes detrimental for persons with mental illness or mental retardation. Solutions will be explored through the Private Hospital Workgroup. • No. Va. needs but does not have a facility like Hiram Davis Medical Center. • Skilled nursing care for persons with mental illness or mental retardation is minimal to nonexistent in No. Va.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• Solutions to the issue of a detrimental hospital emergency room experience will be explored through the Private Hospital Workgroup in 2008 and possibly through an emergency service work group addressing intellectual disabilities/mental health issues.

Question 4. *How does the region handle admissions to state hospitals or training centers after regular working hours or on weekends?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
NVTC is not a 24/7 admission center	• NVTC coordinates with NVMHI for emergency admissions o Established regional protocol to address MR/MI and behaviorally challenged consumers. .	• After-hour requests at NVTC are infrequent. When the requests do occur, the consumer usually has a behavioral problem and needs an immediate bed. NVTC is unable to respond because: o Its staff complements vary by shift o It has no physician on duty 24/7 o Central Office would have to allow decertification of a bed. • NVTC lacks an acute admissions unit.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• There are times when an immediate admission to NVTC is needed but not available. Unlike NVMHI that can provide immediate service to individuals with psychiatric needs based on their danger to self or others, there is no current equivalent residential resource at NVTC for persons with intellectual disabilities and significant behavior issues. • NVTC has no emergency capacity or emergency services.

Question 5. *What are the region's criteria and processes for admission to state hospitals and training centers, and what are the region's processes for resolving disputes about these admissions? What roles and responsibilities has the region identified for the Department in addressing these issues?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier

• A Preliminary Report was prepared by an MR/MI Work Group in March 2006. This will form the basis for additional work that will take place during 2007.
• Criteria are not regionally-based; they are State criteria and include protocols for admission, discharge and dispute resolution.
• If there is a dispute in the region, talk with or write to NVTC director and then write to Commissioner.
• Department has a collaborative role to help solve issue.
• Provide funding for crisis placement instead of using local resources.
• Assist with out of state placements.
• Collaborate with locality in addressing issues of self-advocates.
	• Regional discussion of challenging cases/scenarios.
	• Creation of MR-MI Clinical Response Team (CRT).
	• Regional work groups which include DMHMRSAS representation, resolve issues and propose changes.
	• Protocol has been established for NVTC and NVMHI to facilitate MH/MR consumer care.
		• Need to differentiate between role of training center for persons with intellectual disabilities and a psychiatric hospital for persons with mental illness, some of whom also have an intellectual disability.
		• Need to clarify when appropriate to admit to State facility and when it is not appropriate.
		• Limited regional resources, particularly for MR population, dually diagnosed MR/MI, skilled nursing care or persons on NGRI status.
		• Systemic challenges as a result of a bifurcated system of care that treats MH and MR as separate entities and presents obstacles for coordinated care.
		• Lack of State money and support that may be flexibly used during emergency situations
		  o Department often refers issue back to region instead of supporting local staff in finding solutions
		  o If a CSB must sometimes look to out of state placements, it needs a list of out of state placements that are funded by DMAS or DMHMRSAS.
		• Need clarification of DMHMRSAS roles and responsibilities for persons under 65 years of age who have a progressive and deteriorating organic condition and need

Question 5 - Continued		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
		nursing care. • DMHMRSAS can assist with problem-solving, such as facilitating needed system reform, helping change regulations, etc. • Incomplete or inaccurate communication from referring hospitals about persons' acute medical/surgical treatment or diagnostic needs. • Lack of clarity and varying CSB capacity to provide basic medical screening.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• A Preliminary Report was prepared by an MR/MI Work Group in March 2006. This forms the basis for additional work that is currently underway. • A protocol for providing emergency psychiatric help to citizens with intellectual disabilities is included as Appendix 3 of the Northern Virginia Regional Mental Health/Mental Retardation Regional Work Group report of March 2006. • Continue to use the monthly Mental Retardation Directors meetings to resolve issues.	• If services are expanded at NVTC, especially to include the development of flow-through services, then the region will consider broadening representation on NVTC's Admission Committee. Currently NVTC does face-to-face admission instead of simply relying on paper, thereby encouraging community partnership. • Issues arise when person loses Medicaid Waiver funding and no other funding is available for services. • Significant problems are related to workforce issues and lack of sufficient funding. • Licensure should enforce the regulations when a person is suddenly discharged from a placement with insufficient discharge plans. • When an NVTC consumer goes to a nursing home and returns to NVTC, the readmission process is tedious. A workgroup should be established to review

Question 5 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		legal and funding implications and to recommend streamlined processes that meet legal and human rights requirements. • Need on-going education for magistrates on commitment processes in Northern Virginia. • Monitor the possible reorganization of DMHMRSAS management of training centers and psychiatric hospitals. • Recommendation: Need to maintain a visible wait list for the training centers.

Question 6. *How does the region connect admissions to and discharges from (front and back doors) its state hospital and its training center in its regional utilization management processes or activities?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
• No. Va. uses several regional work groups to resolve issues. (See Attachment C) • NVTC and MR Directors meet monthly to discuss regional issues.	• No. Va. has lowest per capita utilization of state facilities in Va. • Compliance with state discharge protocols. • No. Va. CSBs participate in NVTC Admissions Committee, as appropriate. .	• Inadequate State funding to establish a comprehensive data system of care for executive level planning and for staff to review clinical information. • Many MR services are substantially funded by local funds, not State funds. The CSBs will study the extent to which they might share resources. o If the bed is funded with State dollars, CSBs may consider regional sharing of the bed. o If, however, the bed is funded with local dollars, then bed remains a local resource and is not available for regional usage. • Need an array of services to prevent admissions to hospitals and to facilitate discharges.

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue/Recommendation
		Recommendation: DMHMRSAS should assist in finding out-of-state placements when all other avenues have been exhausted. Recommendation: Create an admissions unit at NVTC for persons with behavior issues to become stabilized before moving into other units.

Question 7. *How does the region manage and coordinate State facility and community services for the following populations: individuals with co-occurring mental illness and mental retardation, mental retardation with serious behavior crises, co-occurring mental illnesses and substance use disorders, and substance use disorders, in accordance with State Board Policy 1015 Services for Individuals with Co-Occurring Disorders?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• MR is currently serving 315 adults age 55 and older o Need to plan for services for older adults o High incidence of dementia-related problems for persons with Downs Syndrome. Further explanation will be provided in Interim Status Report in Jan. 2008.	• Implementation of VASIP (Virginia Service Integration Project) has begun throughout the region. • The MR/MI Clinical Response Team has admitted eight consumers to its services since the program began in December 2006. o Five of the eight consumers were diverted from a hospital o Two consumers are being monitored post-hospitalization o One consumer is undergoing a proactive assessment following a prolonged out of state hospitalization.	• Too many competing initiatives without sufficient resources or coordination by DMHMRSAS. • Many consumers need skilled nursing home care that is not provided at NVTC; this is a different level of care than an ICF-MR.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• The MR/MH Clinical Response Team (CRT) services were initiated in December 2006. During 2007, 31 persons have been served by the CRT: 9 received crisis prevention services 6 received crisis stabilization services 7 were diverted from hospitalization 9 received intervention services while they were hospitalized Estimate that 475 fewer hospital days were used because of the work of the CRT.	• Lack of community-based skilled nursing home care. • Have some but insufficient service resources for special populations. • Providers are reluctant to work in Northern Virginia because of low rates. • Mental Retardation and Mental Health staffs need education and training on a variety of topics: Recommendation: Use training tapes from the CRT and RCSC. Recommendation: Continually educate community providers on the roles of CRT for outpatient assistance.

Question 7 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		Recommendation: Raise awareness among primary caregivers of dual-diagnosis issues. Recommendation: Provide interventions in natural settings. • If the student elects to enter NVTC when funding through the Comprehensive Services Act ends, the student forfeits his right to special education he would have had until age 22.

Question 8. *How does the region ensure that its regional utilization management teams have the ability and capacity to address the unique circumstances and specialized needs of other specialized populations, including older adults and consumers with a forensic status?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
Defer to January Interim Report		•
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• In 2007, CSBs identified 274 older adults (55 years old and older) with intellectual disabilities who were receiving community services and an additional 48 who were residing in training centers. • Persons with mental retardation show signs of aging earlier than the general population.	• Support for the Report of the Study of the Mental Retardation System in Virginia.	• One option for serving older adults is a "progressive nursing" model so that consumers may age in place with additional medical care; such services may be located at NVTC or in the community. Need specialized services for persons with major medical problems. • Public and private community homes need to be prepared to care for consumers in their current environment as they age and acquire various medical conditions. • Work collaboratively for skill building with the Northern Virginia Joint Training Coalition to develop skills in serving special populations. • Need a systematic approach with forensic consumers who have intellectual disabilities. Solutions require regional strategic planning, additional resources and flexible funding. • A rapid response is needed when consumers often have additional issues, e.g., substance abuse problems, non-verbal. • Some persons with intellectual disabilities do not quality for Medicaid Waiver and need general funds for services due to lack of citizenship and other reasons. • Special education graduates may not have services after graduation.

Question 8 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
		• Need to be proactive with consumers with intellectual disabilities/mental health issues. • Regional planning is needed to address community services. • Lack of general medical care. • Need funding differential and pay raises to attract and retain competent staff so that program choice is available.

Question 9. *What roles and responsibilities have the State facilities and CSBs identified and agreed upon for the State facilities in the region and how do they support fulfillment of those roles and responsibilities?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
		• NVTC is not licensed for skilled nursing care.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• Roles and responsibilities of training center are to admit people who meet eligibility criteria and choose a facility ICF-MR.	• Regional Community Support Center (RCSC) provides and shares resources to prevent unnecessary institutionalization. • Support for the Report of the Study of the Mental Retardation System in Virginia, especially as it pertains to Medicaid reimbursement for services.	• Sometimes a gap in services exists between services offered in the community and those in the training center. • RCSC billing for services is limited by who may bill and the types of services for which reimbursement may be received. For example, most consumers need dental care for which there is virtually no Medicaid reimbursement. Recommendation: Address roles and responsibilities in 2008 Mental Retardation Study of Service Delivery System and in the Report of the Study of the Mental Retardation System in Virginia.

Question 15. *How does the region address inter-regional utilization management issues, such as admissions to state hospitals or local psychiatric inpatient programs, crisis stabilization programs, or training centers from outside the region, with other regions? What are the dynamics of the movement of consumers into and out of the region? How easily are representatives from other affected regions able to participate with the region in discussions about these issues? What roles and responsibilities has the region identified for the Department in addressing these issues?*

APRIL 2007 PRELIMINARY REPORT	Success	Immediate Barrier
• Medicaid Waiver regulations, encouraging freedom of choice, does not lend themselves to regional utilization management of MR services. Waiver consumers may move as they wish. • 77 consumers are placed in training centers other than NVTC.		• Because consumers' rights to a training center placement are waived when they apply for the Medicaid Waiver, NVTC has no wait list. Consumers are encouraged to apply for admission when they really need it. • No. Va. faces multiple work force issues, including inability to pay competitive wages. In addition, the work force is faced with high cost of housing and transportation. • It is often problematic to return some MR residents who reside in training centers other than NVTC to No. Va. These consumers are often long-term residents of the out of area training center, are receiving good care and have no relatives in No. Va. • No skilled nursing at NVTC.
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
• When persons cannot be served in the community and no space is available at NVTC, they are sometimes placed out-of-area. o As of December 2007, 174 persons from Northern Virginia are residing at NVTC and an additional 75 persons are residing in other training centers throughout Virginia.		• General funds are needed for "progressive" nursing services at NVTC; need step-down for meds, medical tests, etc. • Occasionally, a consumer is ready for discharge from NVTC into Northern Virginia but is from another part of the state and does not have a Northern Virginia CSB case manager. Under these circumstances, it is difficult for the

Question 15 - Continued		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
o As of October 2007, CSBs identified 23 persons who were transferred from their home Northern Virginia CSB to other CSBs in Virginia in 2007; 19 of these consumers went to CSBs outside Northern Virginia. The receiving CSB provides case management services for this group of consumers. o In addition, 79 other consumers are already residing outside their Northern Virginia CSB area but continue to receive case management services from their Northern Virginia CSB. Of these consumers, 56 in the Northern Virginia area and 23 are in other part of the state.		Northern Virginia CSB to plan for the discharge. • When a consumer moves to another part of the state and case management responsibility is transferred to the receiving CSB, Northern Virginia loses the Medicaid Waiver slot. • Insufficient number of Medicaid Waiver slots is available.

Question 17. *How do the region's utilization management processes or activities support the principle of public management of public resources for effective and responsible stewardship of scarce public funds and the achievement consumer-focused public policy goals? This principle is embodied in the single point of entry role of CSBs and their provision of case management services, articulated in STATE BOARD POLICY 1035 Single Point of Entry and Case Management Services.*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
Deferred to April 2008 Interim Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• CRT. • Regional Day Support/Supportive Employment RFP, winner of the first annual Northern Virginia Regional. Commission's Regional Partnership Award • Utilization management is addressed at monthly Mental Retardation Directors meetings. • RCSC is on-going and provides consumer services as well as training and consultation to the regional entities. • Northern Virginia CSBs and NVTC participate in a variety of committees and work groups, including: o Semi-quarterly meetings of the RCSC Steering Committee o Virginia Joint Training Coalition o Vocational managers group o Logisticare (for Medicaid funds for transportation services) o Northern Virginia Coalition (public/private partnerships) o Coalition of Northern Virginia for persons with mental disabilities o Northern Virginia Strategic Planning Partnership o Local Human Rights Commission o Weekly meetings of directors of CSBs, NVTC and NVMHI.	

Question 18. *How do the region's utilization management processes and activities support the realization of the vision in State Board Policy 1036; promote and enhance choices for consumers among service alternatives that most effectively meet their needs, as determined by consumers and their service providers; and focus on addressing the particular needs of each consumer in the most appropriate manner clinically, rather than focusing only on locating available state or community inpatient facility beds?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
Deferred to January 2008 Interim Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
	• Based on consumer needs, admission to training center or NVMHI may be sought. • Local jurisdictions supplement state funding for services.	• The Medicaid Waiver requires choice and services based on individual needs. However, resources are limited. Need more funding to avoid "forced choice." • The CSBs and NVTC support the person-centered concept although they are constrained by funding limitations. • Utilization management is needed for public-private partnerships. Consumers have a choice of many providers as a result of public-private partnerships. • Pending cuts in local funding may negatively impact services. • Need funding differential and pay raises to attract and retain competent staff.

Question 20. *How does the region measure, monitor, evaluate and manage the success of its regional utilization management processes or activities, as defined by the first three conditions in the Definition of Success on page 4, including the effects of those processes or activities on private providers in the region?*		
APRIL 2007 PRELIMINARY REPORT	**Success**	**Immediate Barrier**
Deferred to January 2008 Report		
JANUARY 2008 INTERIM REPORT	**Success**	**Immediate Barrier/Issue/Recommendation**
Condition 1: Inpatient psychiatric hospital beds are available within a reasonable time for individuals in crisis who cannot be diverted to less intensively structured alternatives, such as crisis intervention or stabilization services, and who need these beds.	See response in Mental Health section.	
Condition 2: Intermediate care facility (ICF/MR) beds are available in training centers or the community within a reasonable time for individuals who need this service setting and choose it instead of less intensively structured or specialized alternatives, such as MR waiver services, and emergency or respite admissions are available at training centers for individuals in crisis who need them.	• NVTC and the CSBs monitor admissions and discharges. NVTC also monitors activities at the RCSC.	• The availability of beds is severely limited since NVTC has limited capacity and little turnover. • Recommendation: The CSBs and NVTC will consider other types of reviews in 2008.
Condition 3. State hospitals and training centers do not exceed their operational bed capacities (census).	• NVTC does not exceed its operational capacity.	

Children and Youth Services

Introduction:

The Northern Virginia Strategic Planning Partnership has taken this opportunity to examine regional utilization management (RUM) for Children and Youth Services. Because of time constraints associated with the April 2007 Preliminary Report, a discussion of processes and issues related to Children and Youth was deferred to the January 2008 Interim Report.

The system of care for children and youth emphasizes delivering services in a natural setting – in the child's home, at the child's school, at a recreation center. At times, outpatient services are delivered in a CSB office but still retain a family focus. If more intensive care is required, a child may be stabilized in a crisis care unit, if it is available, or a local psychiatric hospital unit for a few days to a week. Children with more complex problems may be placed at the Commonwealth Center for Children and Adolescents located in Staunton, Virginia. Northern Virginia has no comparable hospital. Should a child require long-term care, the child may be placed at a residential treatment center.

Local and state funding is available to individual CSBs for children and youth services. These services are not funded with regional dollars and are, therefore, not managed as a regional resource. Although some children may qualify for services that are funded through the Comprehensive Services Act (CSA), the service management remains local but coordinated jointly by the schools, social services, juvenile justice and the CSBs. While regional utilization management per se is not used in Northern Virginia, the CSBs meet regularly to resolve system issues, to plan children's services, and to coordinate service delivery. The management of services for each individual child, however, remains the responsibility of the individual CSB.

This document addresses 15 of the 20 RUM guidance questions, those that are directly related to Children and Youth Services.

Question 1. *What actions does the region take when a consumer needs an inpatient psychiatric bed, no private inpatient bed is available, and the state hospital is at capacity?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• If need locked facility, use TDO. • By Code if TDO or 10 day court order, Commonwealth Center for Children and Adolescents (CCCA) must find a hospital bed for children and youth. • If voluntary, work with private hospital.	• Use strength of family as safety plan. • In Fairfax-Falls Church, use Leland Crisis Care Unit (CCU).	• Dominion Hospital admits children/youth but does not take children and youth with a history of violence or sexual acting out behavior. • Need DMMRSAS funds to purchase beds for voluntary admissions. • To use Medicaid funds for inpatient services, children and youth must have a certificate of need with physician sign-off.

Question 3. *Has the region established a time limit on how long consumers who need beds can wait in local hospital emergency departments, and, if so, what is the time limit?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• Most children and youth do not go to hospital emergency rooms for psychiatric problems.		

Question 4. *Has the region established a time limit on how long consumers who need beds can wait in local hospital emergency departments, and, if so, what is the time limit?* How does the region handle admissions to state hospitals or training centers after regular working hours or on weekends?

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• If emergency, state hospital will take Children and youth if they meet TDO criteria and have a TDO. • CSBs can bypass emergency service to admit children and youth if staff is on the magistrate list and are certified; this varies by CSB.		• Children and youth with intellectual disabilities sometimes go to CCCA because training centers do not admit children and youth.

Question 5. *What are the region's criteria and processes for admission to state hospitals and training centers, and what are the region's processes for resolving disputes about these admissions? What roles and responsibilities has the region identified for the Department in addressing these issues?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• State Code: presence of mental illness, imminent danger to self or others, lack of other resources. • Process: CSB Emergency Service prescreening. • Roles and responsibilities identified for Department: provision of psychiatric hospitals; ultimately responsible for TDO placement.	• If dispute, resolve by meeting with CSB, CSA, private provider, CCCA; done on case-by-case basis; use internal CSB chain of command to elevate issue to Executive Director level. • Coordination occurs with Barbara Shue, CCCA.	

Question 6. *How does the region connect admissions to and discharges from (front and back doors) its state hospital and its training center in its regional utilization management processes or activities?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• Use discharge planners (care coordinators) for C/Y; each jurisdiction has discharge planner. • Agree with discharge plan. • No formal regional utilization management.		

Question 7. *How does the region manage and coordinate State facility and community services for the following populations: individuals with co-occurring mental illness and mental retardation, mental retardation with serious behavior crises, co-occurring mental illnesses and substance use disorders, and substance use disorders, in accordance with State Board Policy 1015 Services for Individuals with Co-Occurring Disorders?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• Done through the Comprehensive Services Act (CSA). • Individual CSB discharge planners coordinate state facility and community services. • Sometimes children and youth have access to foster care prevention funds. • Not a regional approach: CSBs have common infrastructure but do not share funds.	• With Medicaid Waiver, can have in-home and respite services.	• If non-mandated child or youth and no funds are available, child or youth may be placed on the individual CSB wait list for services provided by the individual CSB. • No state regional funds that necessitate and facilitate regional management and coordination.

Question 9. *What roles and responsibilities have the State facilities and CSBs identified and agreed upon for the State facilities in the region and how do they support fulfillment of those roles and responsibilities?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
		• No state facilities for C/Y in region. • Need C/Y state facility in Northern Virginia. • Transportation is an issue when Northern Virginian C/Y are placed at CCCA. • Distance is contraindicated for system of care approach and to promote necessary family therapy when youth is hospitalized. For example, families must travel three hours to visit youth placed at CCCA.

Question 10. *How does the region discuss and attempt to resolve utilization management conflicts or raise problems to the region's leadership? What are the Department's roles and responsibilities in these areas?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• Refer issue through CSB chain of command using existing modes of communication. • No regional approach.		

Question 11. *How does the region use its regional utilization management processes or activities to ensure that consumers are served in the least intrusive and most appropriate settings and as close to their homes as possible, for instance, so that consumers are admitted to local psychiatric inpatient beds or crisis stabilization beds before they are admitted to state hospital beds, unless compelling clinical needs or circumstances or the unavailability of these community alternatives warrant direct admission to state hospital beds? Also, how does the region use its regional utilization management processes or activities to ensure that consumers who no longer need acute care services do not remain in those settings?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
• Psychiatric hospital is used for stabilization; if need long-term placement, then residential treatment facility is used. • CSA is used for long-term care as well as other community-based services. • With CSA funding, get psychiatric bed or home-based services.	• Fairfax-Falls Church has the only CCU for youth but it is not currently regional.	• Less restrictive alternatives are expected to be explored by individual CSBs and CSA. • CSBs that do not have a CCU have limited resources as alternatives to hospitalization. • Short-term psychiatric hospitalization is used while CSBs access alternative services.

Question 13. *When and how does the region involve the private sector, especially local hospital emergency departments and psychiatric units and private providers of community mental retardation services, in its regional utilization management processes or activities?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
	• Regional meetings with private sector but do not discuss utilization management per se; discuss challenges.	• No regional utilization management. • Private hospital contacts with each jurisdiction for discharge planning so that more expensive services are not automatically encouraged; however, CSBs cannot mandate this process.

Question 14. *When and how does the region involve consumers, family members, law enforcement, and the criminal justice system in its regional utilization management processes or activities?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
	• Northern Virginia CSBs meet regularly to discuss issues but not to do regional utilization management. • Each CSB has a Community Policy and Management Team with a parent representative as well as a Family Assessment and Planning Team where consumers, family members, law enforcement, criminal justice, social service and mental health representatives participate in the CSA processes; however, not all children and youth who receive mental health services are CSA eligible.	• Consumers, family representatives, law enforcement representatives do not attend meetings.

Question 15. *How does the region address inter-regional utilization management issues, such as admissions to state hospitals or local psychiatric inpatient programs, crisis stabilization programs, or training centers from outside the region, with other regions? What are the dynamics of the movement of consumers into and out of the region? How easily are representatives from other affected regions able to participate with the region in discussions about these issues? What roles and responsibilities has the region identified for the Department in addressing these issues?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
	• HPR II has quarterly meeting with CSB Youth and Family managers and the head of social work from the Commonwealth Center for Children and Adolescents (CCCA). • Every six months, the CSB staff is joined with CSA managers from the respective jurisdictions and members from NOVACO and Dominion hospital to discuss individual CSB issues and regional issues that may interface with the private sector. • Outside region issues dealing with the Department and CSA are dealt with at the quarterly state Youth and Family Counsel meeting held at Henrico CSB. This meeting and the State Behavioral Health Policy and Planning Committee meeting are forums for looking at state wide issues.	• No regional funds are available for regional planning and services for children and youth. • Need local psychiatric unit, e.g., a unit for children and youth at NVMHI.

Question 16. *How do the region's utilization management processes or activities support the principle of public management of public resources for effective and responsible stewardship of scarce public funds and the achievement of consumer-focused public policy goals? This principle is embodied in the single point of entry role of CSBs and their provision of case management services, articulated in STATE BOARD POLICY 1035 Single Point of Entry and Case Management Services.*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
		• There are no formal regional management processes other than those described in #15 above. Various stakeholders from the private section are invited to attend meetings.

Question 17. *How does the region communicate and implement its regional utilization management processes or activities to and with all stakeholders in the region?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
	• Since the region has received no public "regional" funds to manage there are no formal regional processes. However, there is the active membership of CSA, CSB, CCCA, private partners and community that participate in the "HPR II cubed meetings."	

Question 18. *How do the region's utilization management processes and activities support the realization of the vision in State Board Policy 1036; promote and enhance choices for consumers among service alternatives that most effectively meet their needs, as determined by consumers and their service providers; and focus on addressing the particular needs of each consumer in the most appropriate manner clinically, rather than focusing only on locating available state or community inpatient facility beds?*

JANUARY 2008 INTERIM REPORT	Success	Immediate Barrier/Issue
		• Each CSA/CSB jurisdiction supports consumer choice, and strategies and best practices are continually shared at the HPR II cubed meetings. • It is hard to achieve consumer choice when inpatient facilities and alternative services are so limited.