REGIONAL MANAGEMENT GROUP MEETING

Date: June 28, 2019 **Time:** 9:00 a.m.

Attendees: Margaret Graham (LDN CSB), Daryl Washington (FFX CSB), Amy Smiley (NVMHI), Jean Post (NVRPO), Randy Buckland (NVRPO), Wendy Rose (NVRPO), Tara Belfast-Hurd (DBHDS), Jamie Elzie (DBHDS), La Voyce Reid (ARL CSB), Betsy Strawderman (PWC CSB), Ollie Russell (ARL CSB), Phillip Caldwell (ALX CSB), Alexis Maples (ARL CSB), Stephanie Costanza (FFX CSB), Roshontia Haas (LDN CSB), Elise Madison (PWC CSB), Gabriel Duer (ALX CSB), MaryJo Blair (LDN), Michelle Petruzzello (LDN CSB), Mira Signer (DBHDS)

Hospital Partners: Jennifer Wicker (VHHA), Karyn O'Brien (Novant), Stephen Smith (Novant), Melissa Preston (Dominion), Edward Speedling (HCA Healthcare), Garrett Hamilton (North Springs), Tammala Watkins (INOVA), Rick Leichtweis (INOVA), David Westcott (PWC Legislative Affairs Liaison)

Recorder: Xiuping Cheung (NVRPO)

Call to Order: Margaret Graham (LDN CSB) called the meeting to order at 9:03 a.m. The group was welcomed, and introductions were made.

Handouts: Agenda, RMG meeting minutes (May 2019), Senator Barker's Budget print out, Mental Health Coordination Workgroup for Acute Services PowerPoint; Region 2 Budget report, Regional Utilization Management Report

TOPIC	DISCUSSION	REC/ACTIONS	RESPON-SIBLE PARTY	F/U DATE
Introduction	• Introductions were made, M. Graham welcomed the group. Minutes from May meeting will be tabled for July meeting because the process has not been established for voting when primary members are absent.			
Senator Barker's budget amendment	• Mira Signer provided a recap on Senator Barker's budget amendment, which is that the department shall facilitate a mental health coordination workgroup in No. VA so that public and private providers of services and advocates for such services may collaborate on the needs in No. VA. This meeting is one of several regional meetings that make up the No. VA. MH Coordination Workgroup. • J. Wicker recommend that consumer advocates be invited to this type of meeting, but later stated that she had not previously understood that this was a part of an existing meeting schedule. D. Washington shared that he did invite advocates to this meeting.			
Community Continuum of Services	• J. Post provided a review of community services available for those at high risk for hospitalization in Region 2. The programs identified included: Regional Crisis Stabilization (34 beds/4 locations); Regional Detox programs (CARE; Woodburn place, CSBs are			

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	working on contracts with INOVA CATs) and local Detox programs; Intensive Community Services; Assertive Community Treatment (Pact/ICT: for high risk individuals); ICM (Fairfax); BH Adult Mobile Crisis Teams; Regional Children's BH Mobile Crisis Team; REACH (Mobile crisis, preventions, CTH); 16 ICRT beds, 4 step down beds with 8 more opening in September (provide wrap around services); CIT assessment centers; RAFT (4 ALF, 5 nursing home contracts); Fairfax and Prince Williams have teamed up with EMT/Police as co-responders – for community outreach.			
Emergency Services diversion efforts, a case review	• Roshontia Haas shared a case example of Emergency Service diversion efforts. o A CSB connected individual arrived at 7am and presented as acutely suicidal with a plan, and a history of SUD as well as BH challenges. Hospital diversion efforts explored included PHP and CSUs. Because of the safety risks associated with this individual, it was determined that PHP would not provide sufficient supervision to ensure safety. One CSU denied the individual because of acute suicidal ideation and concerns that the CSU may not be able to maintain safety; another denied the individual due to addiction. CSUs are voluntary community residential facilities which are not locked. Emergency services contacted 40 hospitals, and none of the hospitals were willing/able to accept this individual. The time involved in the bed search resulted in an escalation of the individual's agitation, and the individual was attempting to leave AMA. ES ended up TDOing the individual to NVMHI as a last resort placement. After medically cleared, it took 4 hours to safely transfer the individual to NVMHI. This process took more than 15 hours and resulted in an escalation of the individual's symptoms. o Last Friday the 21st of June, 3 Loudoun individuals were in 3 separate Emergency rooms under TDOs, no beds were available in private hospitals, the state hospital was unable to accept these individual for admission until after the weekend. Law enforcement was present the whole time, efforts to make process faster were not successful. o In Loudoun County & Prince William County, from ECO to acceptance the average time frame is 15 hours. • Instead of using the emergency room as a holding place for the individuals, the group discussed looking into using the CSUs as a			

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	holding option. Because CSUs are not licensed for this use, A. Smiley suggested coordinating meeting with DBHDS licensure, request a review of licensing rules that regulates the CSUs from being utilized as an alternative placement of the emergency room. • J. Wicker reported that she has had this conversation statewide and has requests licensure information about the CSUs. • Release prior to hearing was discussed. If a physician believes the individual will not meet criteria for TDO and the individual will not sign in voluntarily, then the hospitals are encouraged to consider release prior to hearing. Hospitals were also encouraged to consider stepping the individual down to a CSU before the hearing if appropriate and if individual is willing. • SB14 workgroup is looking at realignment of MH services and focusing on the development of a more comprehensive approach to services. They are reviewing prevention, PACT, PHP, Inpatient care.		J. Post to follow up with Mary Begor of DBHDS	
Accessing private hospital beds and data review	• Mental Health Coordination workgroup for Acute Services; a public/private partnership data package was reviewed with the group. • J. Post requested 2018 private hospital occupancy data from J. Wicker, but the most current publicly available data is 2017. • Fairfax CSB informed the group that as of August 2019, they will be partnering with INOVA Fairfax to do medical clearance in Merrifield Center to free up ER beds. • G. Hamilton suggested that in the future when we are presenting private hospital occupancy data, it would be helpful if we were to separate out freestanding Psychiatric facilities from those imbedded in a med/surg hospital. • D. Washington suggested the group consider a pilot with one hospital in which the region purchases enhanced beds to serve individuals with high acuity. J. Elzie shared that this option is being considered in other areas of the state as well. • G. Hamilton shared that barrier hospitals must serve individuals presenting with aggression is licensing and Human Rights; facilities are cited if an individual with high acuity/aggression hurts another individual. Group will continue exploring these issues.	S. Smith requested ECO data. J. Post requested 2018 private hospital occupancy data G. Hamilton requested separation of private hospital data based on type of hospital.	J. Post J. Wicker J. Post	
Barriers to serving R2 residents in R2	• Capacity issues: o The Treatment Advocacy Center recommends 50 public beds per 100k in population. Region 2 has only 8 public beds per 100k. If we combine the public and private beds, then R2 has 21 inpatient beds per 100,000.			

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	○ R. Buckland has been touring Crisis models in other states with a DBHDS/DMAS/CSB workgroup addressing crisis services as part of STEP VA. RI International is a vendor of Crisis Services utilized in AZ, and they also recommend 50 public beds per 100,000 population. • Occupancy Barriers: ○ Optimal occupancy rates identified in the research are between 82% and 85%. Higher occupancy rates are associated with adverse effects of overcrowding such as violence/aggression towards peers/staff and staff turnover. ○ The most current publicly available data on private hospital bed occupancy is from 2017. At that time, our private partners were operating at 75% of licensed beds and 78% of staffed beds. ○ In FY19, our public hospital is operating at 92% of occupancy; well above safe standards. ○ If our Private Partners were able to serve the FY17 bed days + 2% in FY19 and these individuals could be transferred from the private sector, then the NVMHI occupancy could shift from 92% to 89% occupancy. ○ If our Private Partners were able to serve the FY17 bed days + 5% in FY19 and these individuals could be transferred from the private sector, then the NVMHI occupancy could shift from 92% to 85% occupancy. ○ Simply making this small shift would provide significant relief to our public system. ○ Group discussed barriers to such a shift: ▪ INOVA reporting that they are struggling to secure providers and that as a result they are currently only staffed to be able to provide services to 29 in their adult unit despite their licensed capacity of 41. ▪ Novant has just reopened their beds based on provider hires. ○ Group discussed workforce challenges: ▪ Cost of living in the area ▪ Limited loan repayment plans as an employment benefit ▪ S. Smith suggested exploring grant opportunities for workforce development which could provide sign-in bonus, cost of living adjustments, loan repayment.		J. Post to share this recommendati	

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	This is likely much less costly than recruiter costs which are currently running at between 40-60K. ▪ Temp MD may be another barrier to hire, as the MDs have no commitments to the hospitals, housing assistance is provided, ability to travel to different location, even out of the country. ▪ Fairfax currently has one individual who started as a resident, was recruited and has remained with the CSB 5-6 years but haven't have any other success with recruiting. • M. Preston suggested that we consider reviewing licensure flexibility related to adult and youth beds, changing the age of the individual to be served based on need without the currently required 60 days' notice to licensing. • Dominion will look at piloting private hospital transferring CMA individuals to NVMHI, in return for insured individuals. • L. Reid shared that there are inpatient service barriers for youth with autism. She invited youth private hospitals to join IDD focus meeting to further discuss this issue.		on with D. Herr of DBHDS	
Round Robin	• Next RMG w/private hospital partners will be held in January 2020. • A. Smiley reported that across the state, there are only 10 public beds available, NVMHI has 5 of the 10. • J. Wicker requested to be included in RUG hospital partner meeting.			

Adjournment: The meeting was adjourned at 11:50 a.m. The next meeting will be on July 26, 2019, at 9:00 a.m. in Chantilly

Recorder 07.26.19 **Date** **Chair** 7-26-19 **Date**