REPORT OF THE
SECRETARY OF HEALTH AND HUMAN RESOURCES

# The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

## HOUSE DOCUMENT NO. 85

COMMONWEALTH OF VIRGINIA
RICHMOND
2005

# *COMMONWEALTH of VIRGINIA*

## *Office of the Governor*

Jane H. Woods
Secretary of Health and Human Resources

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October 31, 2005

The Honorable Mark R. Warner, Governor of Virginia

Dear Governor Warner:

I am pleased to forward to you my Report on the Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities. Item 298 C of the 2005 Appropriation Act directs the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, to examine the feasibility of PPEA proposals for the operation and maintenance of [state] mental health facilities by November 1, 2005.

The study was conducted with the assistance of a staff workgroup from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and state facilities that developed an initial draft of the policy issues and questions, and evaluation criteria required to evaluate such a PPEA proposal. An exposure draft of the report was shared with a Stakeholders Group and was distributed and posted on the website of DMHMRSAS. Comments from the Stakeholders Group meeting and from public comment were incorporated in the final report. In addition, letters and e-mails from private corporations, local governments, Community Services Boards and provider and advocacy organizations are appended to the report.

Many of the issues and questions raised in this study require discussion and decision by policy makers. These critical decisions involve the willingness of the public to entrust a traditional function of state government to the private sector. Access to services for consumers, the quality of services, and the transition of state employees to the private sector are major components of this decision. Before embarking on the use of PPEA for the maintenance and operation of a critically important health care and public safety function the public policy questions outlined herein need discussion, debate and decision.

Thank you for the opportunity to conduct this review.

Sincerely,

Jane H. Woods

JHW/glp
Attachment

# *COMMONWEALTH of VIRGINIA*

## *Office of the Governor*

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October 31, 2005

The Honorable John H. Chichester
Senate of Virginia
Room 626
P.O. Box 396
Richmond, Virginia 23218

Dear Senator Chichester:

I am pleased to forward to you my Report on the Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities. Item 298 C of the 2005 Appropriation Act directs the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, to examine the feasibility of PPEA proposals for the operation and maintenance of [state] mental health facilities by November 1, 2005.

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Sincerely,

Jane H. Woods

JHW/glp
Attachment
Pc: The Honorable William C. Wampler, Jr.
Joe Flores

# COMMONWEALTH of VIRGINIA

## Office of the Governor

Jane H. Woods
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October 31, 2005

The Honorable Vincent F. Callahan, Jr., Chairman
House Appropriations Committee
General Assembly Building, Room 947
P. O. Box 406
Richmond, Virginia 23218

Dear Delegate Callahan:

I am pleased to forward to you my Report on the Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities. Item 298 C of the 2005 Appropriation Act directs the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, to examine the feasibility of PPEA proposals for the operation and maintenance of [state] mental health facilities by November 1, 2005.

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Thank you for the opportunity to conduct this review.

Sincerely,

Jane H. Woods

JHW/glp
Attachment
pc: The Honorable Phillip A. Hamilton
Susan Massart

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## EXECUTIVE SUMMARY

Item 298 C of the 2005 Appropriation Act directs the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, to examine the feasibility of Public-Private Education Facilities and Infrastructure Act of 2002 (PPEA) proposals for the operation and maintenance of mental health facilities. The Secretary is directed to report on the feasibility of the use of PPEA proposals to the Governor and General Assembly by November 1, 2005.

The study was conducted with the assistance of a staff workgroup from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and state facilities that developed initially policy issues and questions, and evaluation criteria required to evaluate such a PPEA proposal. An exposure draft of the report, including the policy issues and questions and the evaluative criteria, was shared with a Stakeholders Group. The exposure draft was distributed and posted on the website of DMHMRSAS. Comments from the Stakeholders Group meeting and from public comment were incorporated in the final report. Letters and e-mail responses from private providers, local governments, community services boards (CSBs), and advocacy organizations are included in **Appendix B** of this report.

Many of the issues and questions raised in this study require discussion by both the Executive and Legislative branches of state government. These critical decisions involve the willingness of the public, and by extension its elected representatives, to entrust a traditional function of state government to the private sector. In addition, access to services for consumers, the quality of services, and the transition of state employees to the private sector are major components of the decision-making process for determining whether to contract state hospital operations. Before embarking on the use of PPEA for the maintenance and operation of a critically important health care and public safety function, the following public policy questions need discussion, debate and decision:

**A.** The provision of inpatient mental health services for consumers who are indigent or who have very difficult or complex conditions is a fundamental and traditional function of state government. These services are critical to maintaining the public safety net and to providing access to quality services. How will privatizing the management of a state mental health facility help or hinder the Commonwealth's responsibility for assuring these services? Given the complexity of the services system, how will privatization affect the facility's relationships with other state facilities, community services boards, and private providers, including providers of acute care?

**B.** Will privatization affect the ability of private acute care hospitals to transfer patients to state mental health facilities when such a transfer is the appropriate placement for the patient? Will privatization lead to a further reduction in the number of beds in state facilities? Will it affect the public service delivery system, including private providers, CSBs, law enforcement, local government,

etc., if some state facilities are operated under contract by a private provider while others continue to be operated by DMHMRSAS?

**C.** As the services system is transformed to a consumer-driven system of services and supports how will the views of consumers and their families be solicited in the decision-making process regarding the potential privatization of state mental health facilities? How open will the decision-making process be?

**D.** What relationship will the private provider have with the State Mental Health, Mental Retardation and Substance Abuse Services Board, or with the State Human Rights Committee in terms of compliance with policy and regulations? How will the statutory oversight responsibilities of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Office for Protection and Advocacy be carried out?

**E.** What will privatizing the management and operation of a state mental health facility mean to the local economy, local governments, and local health care systems? To what extent will efficiencies gained by privatizing the management of a state facility be sustained over time? What will happen to access and quality of care if these efficiencies are not sustained?

**F.** Will a private corporation be willing and capable of responding to external forces and changing demands in order to function as part of a public mental health services system?

**G.** Can a contract be written that reflects the flexible and cooperative nature of the responsibilities shared among the DMHMRSAS, state facility and CSB partners in the current public mental health service system?

**H.** Is the Commonwealth prepared to transition state employees who work for state mental health facilities to private service?

**I.** How will privatizing the management and operation of a state mental health facility help or hinder the facility's provision of a Constitutionally acceptable level of care to consumers?

**J.** How will privatizing the management and operation of a state mental health facility help or hinder the services system's implementation of the Vision of a consumer-driven system of community-based services? Will privatization add a level of complexity to an already complex system or will it be largely transparent to consumers and family members?

**K.** Will the Commonwealth be able to act effectively and quickly if the privatized service needs to be brought back under state management to maintain the continuity and quality of services for consumers and their families?

**L.** How will a private corporation comply with the intent of §§ 37.2-316-37.2-319 of the *Code of Virginia* relating to the restructuring of the services system

Decisions about privatizing services currently operated exclusively by state government require public debate by policy-makers and the citizens. This report outlines the major policy issues and questions that must be addressed in the public forum. **Appendix A** of the report provides a guideline for the private sector to develop public-private partnership proposals and for DMHMRSAS to conduct a thorough review and evaluation of such proposals if policy makers decide that privatization should be pursued. **Appendix B** includes responses to the report.

# I. INTRODUCTION

The 2005 Appropriation Act requests the Secretary of Health and Human Resources to examine the feasibility of public-private proposals for the operation and maintenance of mental health facilities. The budget language was introduced and passed by the House Appropriations and Senate Finance Committees in response to discussions that occurred during the 2005 legislative session with a Florida company, Atlantic Shores Healthcare. Atlantic Shores initiated discussions with state officials and legislators regarding the capital replacement, private operation and maintenance of Eastern State Hospital in Williamsburg, Virginia.

In response to these discussions, the General Assembly requested that the Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services study the issue of privatization, particularly in light of the restructuring legislation passed in 2002.

Item 298 C of the 2005 Appropriation Act states:

> *The Secretary of Health and Human Resources, in coordination with the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services, shall examine the feasibility of Public-Private Education Facilities and Infrastructure Act of 2002 (PPEA) proposals for the operation and maintenance of mental health facilities. In examining the feasibility of such proposals, the Secretary shall solicit comments from an established state and community consensus and planning team for any existing facility impacted by such a proposal or proposals. The feasibility study shall also examine how the proposal or proposals would address the provisions of § 37.2-316, Code of Virginia, which sets out a process for restructuring the system of mental health services involving existing state mental health hospitals including: (i) the development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs; (ii) the resolution of employment issues related to state facility employee transition planning and appropriate transitional benefits, the availability of adequate staff in the affected communities, and specific strategies for transferring qualified state facility employees to community services in the event that a PPEA proposal includes a reduction of current staff; (iii) a six-year projection comparing the cost of the current structure; (iv) a plan for community education; (v) a plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas; and (vi) a plan for assuring the development and implementation of individualized discharge plans for persons leaving the facility. The Secretary shall report on the feasibility of the use of PPEA proposals to the Governor and General Assembly by November 1, 2005.*

## II. BACKGROUND

### A. Restructuring

Section 37.2-316 of the Code of Virginia was passed in 2002, as a result of legislation that was introduced initially proposing to close some state mental health facilities. DMHMRSAS, state legislators, advocacy groups and providers worked together in 2002 to redraft the introduced bill and to craft the current Code language that specifies the procedure for facility closure or conversion to another use utilizing a broadly based community consensus and planning team.

Under this legislation, for the purposes of considering the closure of a state mental health facility, or its conversion to any other use, the Commissioner is required to establish a state and community consensus and planning team consisting of Department staff and representatives of the localities served by the state hospital. The teams must be organized in the jurisdiction where the facility exists and must include local government officials, consumers, family members of consumers, advocates, state hospital employees, community services boards, behavioral health authorities, public and private service providers, licensed (private) hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested persons. In addition, legislators may serve on the team.

The team must develop a plan that addresses the six items included in the budget language set out above. In addition, there are elements that the Commissioner must assure be included in the plan, such as a plan for community education, an implementation plan for required community services, a plan for assuring adequate staff and dealing with state employees, a plan for assuring individualized discharge plans for affected patients, and a provision for suspending the closure or conversion if state funding for facility or community services is reduced by more than 10% from the year of approval to the actual implementation.

### B. Public-Private Education Facilities and Infrastructure Act (PPEA)

The Public-Private Education Facilities and Infrastructure Act of 2002, §§ 56.575.1—56-575.16 was adopted for the stated purpose of "timely acquisition, design, construction, improvement, renovation, expansion, equipping, maintenance, operation, implementation, or installation of...public infrastructure and government facilities." The *Code* states that "it is the intent of this chapter, among other things, to encourage investment in the Commonwealth by private entities and to facilitate the bond financing provisions of the Economic Growth and Tax Relief Reconciliation Act of 2001 or other similar financing mechanisms, private capital and other funding sources that support the development or operation of qualifying projects." Qualifying projects include public buildings and facilities, including certain service contracts.

The PPEA statutes and procedures provide for proposals to be solicited by a state agency or to be delivered by a private entity on an unsolicited basis. As noted above, there is a two-part submission process: each phase of this process requires submission of a monetary fee to the agency.

### C. PPEA Procedures

The Commonwealth of Virginia Procedures for the *Public-Private Educational Facilities and Infrastructure Act of 2002,* issued in December 2002, contain suggested formats for conceptual state (Phase 1) and detailed stage (Phase 2) proposal submissions by private providers. Private providers should follow these guidelines in submitting proposals to DMHMRSAS. The following reviews major components of the submission process.

The organization submitting a proposal is required to submit the following information in the Phase 1 submission:

- Qualifications and experience
- Project characteristics
- Project financing
- Anticipated public support or opposition, or both
- Projected benefit and compatibility, and
- Such additional information as may seem prudent

Suggestions for the Phase 1 Submission under project benefit and compatibility include the following:

- Identify community benefits, including the economic impact the project will have on the Commonwealth and local community, i.e., tax revenue, jobs, pay and fringe benefits of such jobs, training opportunities and number and value of subcontracts generated for Virginia subcontractors.
- Explain the strategy and plan that will be carried out to involve and inform the general public, business community, local governments, and governmental agencies in areas affected by the project.
- Describe the compatibility with the local comprehensive plan, local infrastructure development plans, and any capital improvements, budget or other government-spending plan.

The more detailed Phase 2 submission should include:

- Site plans and details.
- Financing arrangements.
- List of public utilities.
- Plans for securing property.
- Listing of design and construction firms.

- Total life-cycle cost specifying methodology and assumptions of the project and proposed project start date.
- Detailed discussion of assumptions about user fees or rates and usage of the projects.
- Identification of any known government support or opposition through official communications.
- Demonstration of consistency with appropriate local comprehensive or infrastructure development plans.
- Explanation of how the proposed project would impact local development plans of each affected local jurisdiction.
- Description of an ongoing performance evaluation system or database to track key performance criteria.
- Identification of any known conflicts of interest.
- Acknowledged conformance with Ethics in Public Contracting Act.
- Additional material as reasonably requested by the public entity.

Any private entity requesting approval from or submitting a conceptual or detailed proposal to the Commonwealth must provide each affected unit of local government with a copy of those portions of the private entity's request or proposal that are not deemed confidential by the state agency. Affected local jurisdictions have 60 days to submit written comments. The Cabinet Secretary that supervises the state agency provides written approval or disapproval to proceed to a Phase 2 proposal.

Comprehensive Agreements involving any form of state-supported debt, require specific, project-level approval by the General Assembly, the Governor and the Treasury Board. A state agency must have the Governor's approval to enter into a comprehensive agreement for the project.

**D. DMHMRSAS Experience with PPEA (Build Only)**

Items C-137 and C-139.10 of the 2005 Virginia Acts of Assembly, Chapter 951 (the Appropriation Act) authorized the Department of Mental Health, Mental Retardation and Substance Abuse Services, with the concurrence of the Secretary of Health and Human Resources to enter into a comprehensive agreement, pursuant to the PPEA, for the ***design and construction*** of a permanent facility for the Sexually Violent Predator Program (now known as "VCBR") and a ***replacement facility*** for the existing Hancock Geriatric Treatment Center

In February 2003, the Department received an unsolicited proposal from Gilbane Properties, Inc., to finance, design and construct the Virginia Center for Behavioral Rehabilitation (VCBR) on state-owned property in Nottoway County, Virginia. Similarly, in July 2004 the Department received a second unsolicited proposal from Gilbane Properties, Inc. to finance, design and construct a replacement facility for Hancock Geriatric Treatment Center at Eastern State Hospital in Williamsburg.

In both cases the Department implemented the PPEA procedures set forth by the Secretary of Administration in December 2002. The Department decided to accept and consider each proposal, posted public notice of the proposals, and solicited competing proposals. No competing proposals were received for either proposal. After initial review of the Conceptual Stage (Phase 1) proposals, and in concurrence with the Secretary of Health and Human Resources, Gilbane Properties was notified of the Department's desire to proceed to the detailed phase (Phase 2) submission. Based on the Phase 1 and 2 proposals, the vendor's oral presentations, and the Department's evaluations of the proposals and presentations, the Department recommended proceeding with negotiation of a Comprehensive Agreement with Gilbane Properties, Inc. for the construction of a new facility for VCBR, and a replacement facility for Hancock Geriatric Center. The Department is currently negotiating the comprehensive agreements for both projects.

### E. Purpose of the Statutes and the Feasibility Study

The restructuring language of Title 37.2 and the PPEA language of Title 56 address different purposes, that is (i) a public process for determining whether to close a state mental health facility or to convert it to some other use, and (ii) the encouragement of private investment in state infrastructure, technology and services. However, it is clear that PPEA can and is being used for the construction of state mental health facility buildings, such as the reconstruction of the Hancock Geriatric Treatment Center at Eastern State Hospital and the construction of the Virginia Center for Behavioral Rehabilitation. **The area that has not been explored to date, and the purpose of this study is to examine the feasibility of employing the PPEA process for the *operation and continued maintenance* of a state mental health facility.**

## III. METHODOLOGY OF THE FEASIBILITY STUDY

Secretary Jane H. Woods, Secretary of Health and Human Resources, directed Commissioner James S. Reinhard, M.D. to convene a staff workgroup to determine the essential policy questions and criteria that would be needed by the Administration and General Assembly to evaluate the quality of a PPEA proposal to operate and maintain a state mental health facility. The workgroup looked at privatization efforts in other states and reviewed other states' requests for proposals (RFP) for contracting facility operations and services. Department staff worked closely with facility directors, facility staff, and with the Office of the Attorney General to develop a comprehensive draft of public policy questions and evaluation criteria.

An exposure draft was shared and reviewed with an invited Stakeholders Group representing primarily the groups that are required to be included on any state and community consensus and planning team required by the *Code* for restructuring a state mental health facility. Representatives invited to the Stakeholder meeting included DMHMRSAS staff, mental health consumer and advocacy organizations, representatives of local government, state facility directors and administrative staff, representatives of the Community Services Boards, private provider organizations, the State Sheriffs

Association, the State Mental Health, Mental Retardation and Substance Abuse Services Board, representatives of mental retardation and substance use disorder advocacy organizations, the Virginia Office for Protection and Advocacy, and the Office of the Inspector General. Not all of the groups invited to the meeting sent a representative. The exposure draft was posted on the Department's website for a week to solicit public comment. All comments were taken into consideration in the development of the final report submitted to the Governor and General Assembly November 1, 2005.

## IV. VIRGINIA SERVICES SYSTEM

### A. The Public Services System

Title 37.2 of the *Code of Virginia* establishes the DMHMRSAS as the state authority for mental health, mental retardation and substance abuse services. Virginia's public service system includes 16 state facilities, 39 community services boards and one behavioral health authority (referred to as CSBs). CSBs are established by local governments and are responsible for delivering community-based mental health, mental retardation and substance abuse services either directly or through contracts with private providers. They are the single points of entry into publicly funded mental health, mental retardation and substance abuse services with responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. In FY 2004, unduplicated numbers of individuals receiving services in each program area were:

- 100,175 persons received mental health services
- 23,925 received mental retardation services, and
- 53,854 received substance abuse services provided through CSBs.

The 16 state facilities provide highly structured intensive inpatient treatment, residential and habilitation services. Current operating bed capacities are 1,686 for state hospitals (excluding the Hiram Davis Medical Center, with an operating capacity of 74 beds and the Virginia Center for Behavioral Rehabilitation with an operating capacity of 36 beds) and 1,478 for mental retardation training centers.

### B. The Partnership Agreement

Collaboration through partnerships is the foundation of the Virginia public system of mental health, mental retardation and substance abuse services. The Central Office of DMHMRSAS, state facilities and CSBs, which are entities of local governments, are the *operational partners* in Virginia's public system for providing such services.

Annually, the partners enter into a Partnership Agreement to improve the quality of care provided to consumers and to enhance the quality of consumers' lives. The partners share a common desire for the system of care to excel in the delivery and seamless continuity of services to consumers and their families. The partners seek similar collaborations or opportunities for partnerships with consumer and family advocacy groups and other stakeholders. A collaborative strategic planning process helps to

identify the needs of consumers and ensures effective resource allocation and operational decisions that contribute to the continuity and effectiveness of care provided across the public mental health, mental retardation and substance abuse services system.

## V. HISTORY OF THE PRIVATIZATION OF MENTAL HEALTH SERVICES

### A. History of Privatization In Other States

Information on the privatization of mental health services in other states was obtained initially from Ted Lutterman, Director of Data Analysis at the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI). In addition, DMHMRSAS staff obtained information from state agencies. Since the early 1990's, the NRI has been charged with the development and implementation of a state survey to provide a snapshot of mental health activities in all states, which is known as the State Mental Health Agency Profiling System. Recent surveys have questioned the states regarding privatization initiatives for components of the state mental health agencies' systems in that survey year. The data from these surveys is used to develop reports entitled *State Profile Highlights.*

The 2002-2004 *Profiles* indicates that the following states had privatized all or a part of their state mental health system of care, Florida, Arkansas, Connecticut, Kentucky, Illinois, and part of a South Carolina hospital. Most "privatization" has occurred when these states have closed facilities or units and have transitioned patients into community settings where contracts were awarded in the community for services. However, states responded to the *Profiles* document by including private bed purchase in the community as diversion from facilities. This is similar to Virginia's private bed purchase initiative. Florida's privatization effort is by far the most comprehensive in that an entire hospital has been privatized and is run by a private for-profit firm.

Florida's mental health services system is based on a district model. Fifteen district program offices are located throughout the state and are responsible to the central Mental Health Program Office within the Department of Children and Families (DCF). The district offices contract with local Community Mental Health Centers (CMHCs) as well as other providers, agencies and hospitals to provide mental health and substance abuse treatment in the communities. The district offices monitor the contracts, provide technical assistance and other administrative activities.

**1. Florida.** Florida is the only state that contracts with a for-profit organization (Atlantic Shores Healthcare) to run a state mental health facility. In 1997-98, Florida operated four state psychiatric facilities, which are under the state's Department of Children and Families (DCF). One facility, South Florida State Hospital (SFSH) had a number of very old buildings over a 37-acre campus. The hospital had never achieved accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). SFSH typically had 12-13 elopements per month, poor reporting of seclusion and restraint (S/R) episodes, and a high number of patient injuries. During 1998, the problems increased. Communities were unable to get admissions for patients and

patients were not being discharged. In addition, a number of patient deaths occurred. Clinically, the care was custodial: quality assurance was poor; some medical staff conducted private practice during work hours; and an excessive number of employees existed on payroll. The facility was staffed heavily with managers, especially fiscal and nursing; and both psychologists and physicians on long-term care units had very low caseloads.

After much negative media coverage, Florida's legislature directed the DCF to develop a RFP and privatize the entire facility. The RFP called for very strong oversight. Target goals were set in various domains (e.g., construction completion, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) accreditation, reduction in elopements and S/R use), including significant financial penalties for not meeting the targets.

Under the management of Atlantic Shores Healthcare, SFSH met almost all of the target goals. The only exception was the completion date for construction of the new building. Staffing and equipment were two immediate sources of cost savings. Out of approximately 700 staff, 400 were hired. All staff had the option of transferring to another state job. Consolidating services into one building reduced both support service staff (e.g., housekeeping, building and grounds), eliminated duplication of equipment across multiple buildings, and eliminated the need for golf carts and cars to get around the campus. The staff members employed by private management were given a reduced benefits package, but received significantly higher salaries, for example, direct service associates went from approximately $17,000 per year to $24,000.

A key element of success for the Florida contract was that the RFP was comprehensive and "tight", with clear expectations and penalties. In addition, the Florida DCF remained a partner with the SFSH and Atlantic Shores Healthcare administration over time. Other critical elements of success and outcomes of the privatized facility are set out in the following list.

- The DCF participates in hiring the facility management team. The Atlantic Shores Healthcare management team merged modern business principles with mental health values.
- DCF oversight, i.e., two staff are assigned to the campus for daily quality assurance monitoring.
- DCF holds the Mental Health Planning Committees (comparable to CSBs) accountable for failure to meet statutory requirements for discharge planning and for follow-up post-discharge.
- Ongoing communication is essential to the relationship between the DCF and Atlantic Shores Healthcare.
- The state hired a nursing home consultant on retainer to find community placements for elderly patients needing skilled nursing care.
- The state analyzed characteristics and community factors related to recidivism, which was at 16% within 30 days.

- The state created career ladder positions for direct service associates. A Case Manager Discharge Team monitored up to 20 discharged patients at risk of re-admission for a month. They made 2 phone calls per week with the patient and at least 2 face-face meetings to ensure compliance with medication and mental health center appointments.
- Atlantic Shores Healthcare had significant resources that enabled up-front monies for special treatment initiatives.
- The management team hired a consultant to help draw down Medicaid/Medicare monies.
- The new management did not make any profit during the first 3 years of operation.
- Florida rates are low among the states in financing for community services.
- The private operation of SFSH "raises the bar" for performance in many clinical domains for state facilities.

Atlantic Shores has recently been awarded a contract to reconstruct and operate the state's forensic mental health facility, South Florida Evaluation and Treatment Center, located in Miami, Florida. Much like the process at South Florida State Hospital, Atlantic Shores will operate the current facility while constructing a new one for the state.

**2. Arkansas**. The Arkansas Department of Behavioral Health Service (DBHS) has limited authority over the15 Community Mental Health Centers (CMHCs), that are private, non-profits. The state has only two inpatient facilities, a 200-bed psychiatric hospital (civil and forensic) and a 350-bed long-term care psychiatric nursing home for the elderly.

In the mid-to-late 1990's, Arkansas had two deaths of not guilty by reason of insanity acquittees who had been discharged to community programs from the state psychiatric hospital. At that time, there were no secure residential mental health treatment programs in communities. Thus DBHS contracted with Liberty Behavioral Healthcare to operate a 42-bed "step-down" residential program for acquittees who had a dual diagnosis (mental illness and substance abuse) and who had been discharged from the state facility. They paid a flat monthly fee (per diem x 42). The CMHC was responsible for working with each patient from its services area for discharge planning.

In recent years, Arkansas has worked with the CMHCs to develop community-based secure psychiatric residential programs for acquitees that include those with and without a dual diagnosis. One CMHC in the northern part of the state created, and continues to operate, a 16-bed program through use of state Medicaid waivers. The program is in a building at the state mental health facility that was given to the CMHC.

**3. Connecticut.** Approximately 2-3 years ago as part of closing two state facilities the state transitioned patients into community-based initiatives (CBI) or supervised residential programs. The state contracted with multiple private providers to operate the CBIs. Clinical services are delivered by the Local Mental Health Authorities.

Connecticut has unionized facility staff. Initial opposition by the Union to closures was brief, because the transition included employee options of working in other facilities or state agencies or the local CBI. As attrition, transfers, and retirement occurred, the state closed positions and no employees were laid off.

Connecticut has only two remaining state mental health facilities, but operates seven Intensive Outpatient Programs statewide.

**4. Kentucky.** In 1995, Kentucky transferred administrative and operational responsibilities for one state psychiatric facility, Eastern State Hospital, to the Bluegrass Regional Mental Health and Mental Retardation Board. The Bluegrass Board, which is a 501-c (3) organization, operates local community services. The region includes multiple counties. The state contracts for inpatient services with the Bluegrass Regional Board. The transfer of Eastern State Hospital occurred at the request of the Bluegrass Board in concurrence with the State. The transition process took six months, and several million dollars of transition money was allocated to assist with employee transition. State facility employees were given the option of either continuing with their job, which ended their status as a state worker or transferring to another job in the state system. A small proportion took retirement. The major cost was to pay new retirements, pay off leave balances (sick and annual), and transfer retirement funds.

**5. Illinois.** In Illinois, Singer State Hospital purchases patient care for children age 12 and younger from private psychiatric hospitals. At McFarland Hospital the purchase of inpatient care for children and adolescents (C & A) allowed the closure of the state hospital C&A unit. In the Chicago metropolitan area the state purchases all C&A inpatient hospital care from private psychiatric hospitals. All of the mental health networks in the state purchase some inpatient care for the indigent population.

**6. South Carolina.** Forensic programs are being moved to a recently renovated private hospital. In addition to the physical facility, the private provider will provide security and nursing services. However, medical and program staff from the state Department of Mental Health will move with the patients and continue to design and provide patient care, as well as to make treatment and discharge decisions.

### B. Earlier Privatization Efforts

In the 1980s and early 90s there were two efforts at privatization. First, Tennessee issued a Request For Proposals to privatize one of its state hospitals. No one submitted a bid the state found acceptable. Second, Montana built a new state children's mental health facility, and then sold it to a private company with an agreement the state would get a specified number of beds. The state quickly exceeded its contract number of beds, and had to spend much more than it planned for the care of children in the privatized state hospital.

## C. Virginia DMHMRSAS Experience with Privatization of Forensic Services

In 1997, the U.S. Department of Justice (DOJ) initiated an investigation of Central State Hospital (CSH) for violations of the Civil Rights of Institutionalized Persons Act (CRIPA). The major findings of DOJ pertaining to forensic services at that time were:

- Lack of adequate and appropriate rehabilitative and treatment services;
- Significant patient over-crowding in the maximum security unit; and
- Inadequate space for essential treatment programming.

Demand for forensic services was increasing and the forensic unit at CSH regularly operated above its operational census. This situation jeopardized the unit's ability to provide appropriate treatment and to protect patients and staff from harm. Major renovations were needed in Building 39 (the maximum security forensic unit) to provide appropriate space for treatment programming and to enhance on-unit and building security. Patient units had to be vacated and an alternative site had to be found so that renovations could proceed in a manner that ensured patient safety and security standards.

DMHMRSAS issued a Request for Proposals (RFP) to out-source services for forensic patients referred by community jails for evaluation and treatment. Liberty Healthcare was the only provider that responded to the RFP. Subsequently, DMHMRSAS entered into contracts with Liberty Healthcare (November 20, 1997) and the Riverside Regional Jail in Hopewell (October 15, 1997) for healthcare management services and leased treatment space and support cost, respectively. The construction and renovation of the Building 39 project began on October 29, 1997 and was completed on April 20, 2001.

Liberty was required by contract to comply with clinical standards, including JCAHO accreditation, the DOJ CRIPA plan of improvement, and licensing by DMHMRSAS. The contract required that CSH provide all necessary ancillary and support services, including medical, laboratory and pharmacy services performed at the Hiram Davis Medical Center on the Southside DMHMRSAS campus. CSH was also responsible financially for any specialized medical and surgical care deemed necessary and appropriate for the jail inmates during their treatment stays. The contracts were continued through early 2003.

During the contract period, contract costs for the Liberty Healthcare services and for the leased regional jail space increased significantly. In addition, Riverside Jail was experiencing overcrowding in other units and needed additional bed space for inmates. At this time, DMHMRSAS evaluated the cost-effectiveness of services provided by Liberty and the Riverside Regional Jail and concluded that significant cost-savings and administrative efficiencies could be realized by terminating the contract and bringing these services back to CSH. By March 15, 2003, all patients at Riverside were brought back to CSH at an annual cost-savings of approximately $990,000 in administrative fees charged by Liberty, and savings of approximately $630,000 in annual rental fees and support costs charged by Riverside Regional Jail.

(See response from Liberty Healthcare Corporation in **Appendix B** of this report).

## VI. PUBLIC POLICY ISSUES AND QUESTIONS FOR VIRGINIA

As part of its charge, the workgroup and Stakeholders engaged in discussions about issues and questions that should be addressed by the Commonwealth before deciding to contract the **operation and maintenance** of a state mental health facility. It is important to note, that these questions and issues are only relevant if the PPEA process is used for contracting the management and operations of a facility. As previously stated, PPEA has been and is being used successfully for the construction of state mental health facility buildings.

Many of the issues and questions raised in this study require consideration and discussion by both the Executive and Legislative branches of state government. These critical decisions involve the willingness of the public, and by extension its elected representatives, to entrust a traditional function of state government to the private sector. In addition, access to services for consumers, the quality of services, and the transition of state employees to the private sector are major components of the decision-making process for determining whether to contract state hospital operations. The complex nature of the mental health services system includes in many cases the involvement of local government, law enforcement, the judiciary, public and private treatment professionals, human rights advocates, consumers, the legal community and consumer and advocacy organizations. Issues of appropriate treatment may also involve issues of public safety that must be dealt with by communities and policy makers. Before embarking on the use of PPEA for the maintenance and operation of a critically important health care and public safety function, the following public policy questions need discussion, debate and decision:

**A.** The provision of inpatient mental health services for consumers who are indigent or who have very difficult or complex conditions is a fundamental and traditional function of state government. These services are critical to maintaining the public safety net and to providing access to quality services. How will privatizing the management of a state mental health facility help or hinder the Commonwealth's responsibility for assuring these services? Given the complexity of the services system, how will privatization affect the facility's relationships with other state facilities, community services boards, and private providers, including providers of acute care?

**B.** Will privatization affect the ability of private acute care hospitals to transfer patients to state mental health facilities when such a transfer is the appropriate placement for the patient? Will privatization lead to a further reduction in the number of beds in state facilities? Will it affect the public service delivery system, including private providers, CSBs, law enforcement, local government, etc., if some state facilities are operated under contract by a private provider while others continue to be operated by DMHMRSAS?

**C.** As the services system is transformed to a consumer-driven system of services and supports, as articulated in the Vision Statement discussed in the following section of this report, how will the views of consumers and their families be solicited in the decision-making process regarding the potential privatization of state mental health facilities? How open will the decision-making process be?

**D.** What relationship will the private provider have with the State Mental Health, Mental Retardation and Substance Abuse Services Board, or with the State Human Rights Committee in terms of compliance with policy and regulations? How will the statutory oversight responsibilities of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, and the Virginia Office for Protection and Advocacy be carried out?

**E.** What will privatizing the management and operation of a state mental health facility mean to the local economy, local governments, and local health care systems? To what extent will efficiencies gained by privatizing the management of a state facility be sustained over time? What will happen to access and quality of care if these efficiencies are not sustained?

**F.** The Regional Restructuring Partnerships initiated by DMHMRSAS over the past three years have defined the role of the private sector as an entity that the public sector works with collaboratively to accomplish the best possible care for persons with mental illness. State and local governments are accountable to the citizenry and may be required because of public need to adjust the mental health services system according to what is in the best interests of the community and the Commonwealth. While it is clear that the private sector is a vital partner in the system of care, private providers do not hold the ultimate responsibility or liability for the public safety net of services. Contracting for services that are essential to the fundamental purpose of government requires extreme caution. The Commonwealth can delegate authority for operation and maintenance, but not its responsibility to the citizens of Virginia. Will a private corporation be willing and capable of responding to external forces and changing demands in order to function as part of a public mental health services system? For example, a natural disaster may require that the facility accept temporary transfers of hundreds of patients for days or weeks, placing considerable strain on the staffing and operation of the facility and incurring unanticipated and unfunded costs.

**G.** Can a contract, no matter how extensive or detailed, be written that reflects the flexible and cooperative nature of the responsibilities shared among the DMHMRSAS, state facility and CSB partners in the current public mental health service system?

**H.** Is the Commonwealth prepared to transition state employees who work for state mental health facilities to private service? The compensation and benefits package should be comparable to state salary and benefits and should include a provision for crediting state service toward retirement. If privatization occurs, the

Commonwealth must include sufficient time for a full explanation and negotiation of elements of the compensation package, with some prospect for modifications on the basis of negotiation. Regardless of the final decision, discussion of privatization creates anxiety and may destabilize the workforce currently employed by DMHMRSAS at state facilities. In addition, concerns regarding privatization may negatively impact recruitment and retention.

**I.** How will privatizing the management and operation of a state mental health facility help or hinder the facility's provision of a Constitutionally acceptable level of care to consumers? Will privatization trigger the attention of the Department of Justice (DOJ)? Any changes (particularly reductions) in staff to patient ratios must be considered very carefully to ensure that the underlying staffing principles upon which the DOJ settlement agreements were negotiated are maintained.

**J.** How will privatizing the management and operation of a state mental health facility help or hinder the services system's implementation of the Vision of a consumer-driven system of community-based services? (See the following Section). Will privatization add a level of complexity to an already complex system or will it be largely transparent to consumers and family members?

**K.** Will the Commonwealth be able to act effectively and quickly if the privatized service needs to be brought back under state management to maintain the continuity and quality of services for consumers and their families?

**L.** How will a private corporation comply with the intent of §§ 37.2-316-37.2-319 of the *Code of Virginia* relating to the restructuring of the services system? These sections require that any funds saved by restructuring or any proceeds from the sale of vacant buildings or land be retained by the services system and reinvested to improve or expand services in the region served by that facility.

## VII. PRIVATIZATION AND THE VISION OF A CONSUMER-DRIVEN SYSTEM OF SERVICES

The Department of Mental Health, Mental Retardation and Substance Abuse Services has been involved in a multi-year strategic planning process. Seven Regional Strategic Planning Partnerships and five statewide Special Population Workgroups have worked together in a collaborative process to examine emerging trends; assess services system strengths, opportunities, challenges, and critical issues; explore opportunities for restructuring the current system; and develop recommendations for an Integrated Strategic Plan. This process has resulted in significant progress toward the development of new community services such as crisis stabilization programs operated by CSBs, jail services teams managed jointly by CSBs and facility staff, and the development of discharge assistance plans that are monitored jointly by the CSB and facility. These are just a few examples of the progress made in recent years to improve the partnerships among the department, facilities and the CSBs. It is essential that the partnerships be

preserved to implement the goals and recommendations of the Integrated Strategic Plan. The cornerstone of the Integrated Strategic Plan and the future direction of the services system is the Vision Statement that follows. The Vision Statement is embraced by public and private organizations, consumers, families and advocates and was adopted as State Board policy in September 2005.

### A. Vision Statement

Our vision is of a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships.

### B. Guiding Principles

The Vision statement is supported by 8 core principles that DMHMRSAS uses in decision-making. Briefly, these principles are:

- Self-determination, empowerment, and recovery
- Accountability
- Access
- Quality of Services
- Partnerships
- Coordination
- Funding
- Efficient Use of Resources

The Vision statement guides the mission and values of the Department, and is being incorporated into the mission and values of community programs. These guiding principles of the Vision provided the focus for determining the process and criteria required for evaluation of a PPEA proposal for operation and maintenance of a facility. The process recommended by the Secretariat and DMHMRSAS follows.

## VIII. MAKE OR BUY ANALYSIS

### A. Decision-Making Process

Careful and deliberate consideration must be given to the decision of whether or not a private entity should operate and maintain a state mental health facility. The process that should be followed in making this decision should parallel the make or buy analysis procedures outlined in Annex 4-C of the Agency Procurement and Surplus Property Manual issued by the Department of General Services/Division of Purchases and Supply.

A make or buy analysis offers an opportunity for increasing the provision of government-operated services by private sector entities and for removing government from activities that might more appropriately be provided by the private sector.

## B. DMHMRSAS Recommendation and Phases

The make or buy analysis recommended by DMHMRSAS was developed primarily from the procedures referenced above. Much of the following analytical structure is adapted directly from those procedures.

1. Phase One of the analysis is to conduct an inventory of services currently provided by the state agency or services the state agency plans to provide. The agency must consider the public acceptability of contracting with a private entity. This requires determining which services are close to the fundamental purpose of government or are essential to the government's ability to protect the health, safety and welfare of its citizens. That is, essential public services require a higher level of scrutiny in the decision-making process. The guidelines recommend that agencies use caution in considering services of this nature for provision by contractors. Some parts of a particular service may be suitable for contractor provision while others may not.

2. Phase Two of the analysis is a determination of the cost of providing the services in-house. This phase requires the agency to determine the number of full time equivalent employees required to provide the service along with all other costs of service provision. The total in-house cost must be compared with the net contract cost. For services provided in-house currently, the agency must determine if there is a more efficient way to provide the services. If improvements are needed to enhance efficiency, these changes can be taken into consideration in comparing the net contract cost.

3. Phase Three involves determining the feasibility of contracting out. The elements of this phase of analysis are critical for decision-making with regard to the private operation of state mental health facilities. This phase involves 7 critical evaluative steps. These are:

a. Determine the availability of private providers.
b. Determine that the agency's contract administrator successfully completed the Department of General Services/Division of Purchases and Supply training or other appropriate training and that necessary personnel and procedures are in place to effectively administer the contract and monitor contractor performance. A trained administrator or project officer is critical to a successful privatization program. In addition, the agency must assess the cost to the agency of having a qualified administrator who can oversee and assure that quality services are provided and to monitor the daily operations and delivery of services.
c. Consider the impact on the agency's ability to bring the service back in-house if substantial capital equipment and human resources investment is involved and contracting out provides unsatisfactory results.
d. Consider the impact on displaced employees and what provisions can be made for their continued employment, such as being hired by the contractor or retrained for other state service.

e. Prepare and issue a formal solicitation [Invitation for Bids (IFB) or Request for Proposals (RFP)] based on the scope of services, performance standards, job analysis, etc., in accordance with the Agency Procurement and Surplus Property manual (APSPM). (In the case of a PPEA proposal for operation and maintenance of a state mental health facility, the evaluation may be of either solicited or unsolicited PPEA proposals).
f. Prepare an estimate of the State's net cost of contracting the service. This includes the projected contract price; contract administration, e.g., audit, performance evaluation, communication; and other management costs, such as salaries, fringe benefits, etc.; contractor support costs, such as any space to be provided to the contractor; and "one time" costs or savings, such as solicitation costs, staff training, savings from sale of surplus property; personnel costs or savings, such as severance pay, unemployment benefits; savings on real property for the function, etc.
g. Compare estimates of net contract cost to in-house cost. Existing or optimum in-house cost should be used for this comparison. However if optimum cost is used and becomes the basis to retain the service in-house, the necessary improvements must be promptly implemented.

**4.** Phase Four involves a review of the requirements, materials and deliverables specified in **Appendix A** of this report to determine whether the contractor has complied with the required specifications for the proposal, has thoroughly and satisfactorily addressed all of the questions, and has provided all of the required deliverables with the proposal. The criteria listed in **Appendix A** are the most critical elements that DMHMRSAS will evaluate if a proposal is to be reviewed in the near future. However, the department reserves the right to ask for other information or to modify the material to be provided, the questions to be answered, the deliverables, and/or the evaluation criteria as proposals are submitted and as experience with the private management and operation of state facility services provide additional data for contract negotiation, management and evaluation.

**Appendix A** outlines 6 critical areas that must be addressed by the organization submitting a proposal, including materials that will be required to be delivered with each proposal, questions to be answered by the proposing entity, and a list of specific deliverables. Some of the elements set out in the following sections may also be required to comply with PPEA procedures. It is not intended that submissions be redundant; however, the organization submitting a proposal should address each of the listed elements.. The 6 critical areas are:

a. Policy/Regulatory/Legal Issues/Accountability/Oversight/Continuous Compliance
b. Services and Quality
c. Support Services
d. Human Resources
e. Infrastructure Development and Maintenance
f. Fiscal (Cost, Financial Feasibility, Revenue Impact)

**5.** Phase Five of the make or buy analysis involves making the final cost determination of whether or not to contract the service. At this Phase the public policy issues outlined earlier in this report must be examined with clear guidance from the Executive and Legislative branches of government.

In this Phase 5, the decision points for ***financial consideration only*** are:

a. Has the organization submitting a proposal responded to all of the information requested in **Appendix A** of this report?
b. If the net cost of contracting is equal to or less than the in-house cost and the quality and reliability of services are at least equal, DMHMRSAS may proceed with award of the contract.
c. If the net cost of contracting is higher than the in-house cost or the quality and reliability of services are not at least equal, DMHMRSAS may provide/continue to provide the service in-house and may cancel the solicitation and reject all bids/proposals received.

**6.** Phase Six is to review and reevaluate. The agency and project administrator must review contracts continually to ensure that the costs stay below those estimated for in-house provision. The original estimate for in-house costs should be adjusted for inflation to properly compare them with contract costs.

## IX. CONCLUSION

The feasibility of PPEA proposals for the operation and maintenance of state mental health facilities is dependent on a number of key policy questions and circumstances. Over the last four years, the public partners in Virginia's system of care, state facilities, CSBs, and DMHMRSAS, have worked to strengthen the joint ownership and responsibility for the delivery of services. These efforts have resulted in a shared vision for system transformation, improved continuity of care, improved utilization and resource management, enhanced consumer outcomes, and shared accountability. As decisions regarding privatization are considered, they must be made within the context of the positive direction that Virginia's public system of care is moving and with the ultimate goal of enhanced services for consumers.

Currently, Virginia is not facing the situation encountered by other states that are responding to investigations by the U.S. Department of Justice. In the Commonwealth of Virginia, current state facility directors and staff, working together with their partners in each region, can realize efficiencies and savings in their operations if they are able to provide services in newly constructed, state-of-the-art buildings designed to accommodate the needs of persons from their regions with complex psychiatric, medical, and physical disabilities.

Decisions about privatizing services currently operated exclusively by state government require public debate by policy-makers and the citizens. This report has outlined the major policy issues and questions that must be addressed in the public forum. **Appendix**

A of the report provides a guideline for the private sector to develop public-private partnership proposals and for DMHMRSAS to conduct a thorough review and evaluation of such proposals if policy makers decide that privatization should be pursued.

## APPENDIX A

## I. EVALUATION PROCESS AND CRITERIA

### A. Policy, Regulatory, and Legal Issues , Accountability and Continuous Compliance

**1. Materials to be Provided with Each Proposal:** The organization submitting a proposal shall include the following materials with the proposal.

a. Policies, procedures, and plans that address and comply with Virginia's human rights regulations, including the following components:

- Assurance of consumer rights;
- Consumer complaints, including abuse and neglect;
- Consent for treatment and substitute decision making;
- Consumer involvement in treatment planning and decision making;
- Use of seclusion, restraint, and time out; and
- Privacy and authorization to use and disclose protected health information.
- Achievement and maintenance, as applicable, accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or certification by the Centers for Medicare and Medicaid Services (CMS) and licensure by the applicable state agency.

b. The licensing and accreditation or certification history of the organization submitting the proposal, including information about all citations or negative actions taken by regulatory entities over the last six years, such as sanctions, consent agreements, CMS removal of deemed status certification, and revocation actions that the organization has experienced in any state.

c. Copies of current JCAHO, CMS, or other applicable accreditations or certifications and state licenses to operate an inpatient mental health or a mental retardation facility and the reports of the two most recent JCAHO or CMS surveys and state licensure visits.

d. Current or proposed policies and procedures that address compliance with all applicable federal and state statutes, regulations, and policies including:

- Virginia Public Procurement Act,
- PPEA
- Virginia Freedom of Information Act
- Government Data Collection and Dissemination Practices Act,
- Applicable provisions of Title 37.2 of the *Code of Virginia*, including oversight by the Office of the Inspector General (§§ 37.2-423—37.2-425).

- Reports to and oversight by the Virginia Office for Protection and Advocacy §§ 51.5-39.1—51.5-39.12 of the *Code of Virginia.*

- Various federal and state anti-discrimination statutes and regulations (e.g., Titles VI and VII of the Civil Rights Act of 1964, Civil Rights Act of 1991, Equal Pay Act of 1963, Sections 503 and 504 of the Rehabilitation Act of 1973, Vietnam Era Veterans Readjustment Act of 1974, Age Discrimination Act in Employment of 1967, Americans with Disabilities Act of 1990, and Virginians with Disabilities Act of 1991)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- CMS regulations
- State Mental Health, Mental Retardation and Substance Abuse Services Board Policies
- State Human Rights Regulations, and
- Departmental Instructions.

e. Annual statistics by type of service or unit for the organization submitting a proposal for the past six years that describe its operations, including:

- Number of individuals served,
- Numbers of admissions and discharges,
- Average length of stay,
- Number, type, and outcome of complaints for allegations of abuse and neglect,
- Number, type and outcome of all other consumer complaints,
- Number of suicides,
- Number of medication errors,
- Numbers related to use of seclusion or restraint, and
- Number of injuries and deaths during use of seclusion or restraint
- Number of Sentinel Events requiring reporting to JCAHO

f. Policies, procedures, and plans to integrate into its operations a consumer-focused services system that promotes consumer recovery, self-determination, and resilience into its operations.

**2. Questions to be Answered by the Organization Submitting a Proposal**

a. How will your organization implement the state's human rights regulations, including affiliation with a local human rights committee, participation in investigations, and resolution of complaints?

b. How will your organization protect the people served by the program from abuse and neglect?

c. What actions will your organization take to integrate the system's vision statement for a consumer-focused services system that promotes consumer

recovery, self-determination, and resilience into your policies, procedures, and operations?

d. How will your organization address, integrate, or participate in the state's risk management and quality improvement activities?

e. How will your organization provide necessary information about consumers and services to the Department and to the community services boards that it would be serving?

f. How will your organization handle reporting requirements to the Virginia Office for Protection and Advocacy (VOPA), the state's Protection and Advocacy for the Mentally Ill (PAMI) agency?

g. How will your organization relate to the Virginia Office of the Attorney General regarding legal representation and defense issues?

h. How will your organization respond to being subject to inspections and visits from the Office of the Inspector General?

i. How will your organization address applicable provisions in the Central Office, State Facility, and CSB Partnership Agreement?

j. How will your organization address and provide financial accountability to the Department, the General Assembly, and the Auditor of Public Accounts?

k. How will your organization integrate its automated clinical or management information system with the Department's AVATAR (State Facility Information Patient/Billing System)?

l. How will your organization ensure compatibility with VITA requirements regarding software applications, operating systems, and security?

m. How will your organization integrate or coordinate (if allowed) its procurement activities with the state's electronic procurement system (eVA)?

n. How will your organization comply with all of the statutory requirements applicable to state hospitals, including those listed in Appendix A, Title 37.2 Facility Operations Legal Concerns and Questions?

o. How will your organization relate to the local courts in addressing the legal status/admission processes at the facility?

p. How will your organization integrate into the public system of care where the CSBs are responsible for crisis intervention services, prescreening admissions to the hospital, and community placements/discharges from the hospital?

## B. Services and Quality

**1. Materials to be Provided with Each Proposal:** The organization submitting a proposal shall include the following materials with the proposal:

**a. Admissions:**

- Any current policies and procedures related to admissions or the admissions process
- A plan that addresses the special needs of clients, especially related to the admission of forensic clients and clients admitted pursuant to temporary detention orders for commitment.
- Any current policies and procedures regarding the evaluation of the medical necessity for admission and the quality monitoring of the admissions process.

**b. Assessments:**

- Policies and procedures related to all assessments including medical, nursing, psychology, psychiatry, social work, occupational/recreational/physical/speech therapies, nutrition and risk. Include a schedule of times for re-assessments.
- Current policies related to quality monitoring of the assessment process and the quality of the assessments.
- Documentation that assessments meet CMS and JCAHO requirements.

**c. Treatment:**

- Current policies and procedures regarding individualized treatment planning
- Policies and procedures for development of patient behavioral plans
- Current or proposed elements of the psychosocial rehabilitation program
- Quality monitoring process for treatment teams and programming
- Policies and procedures regarding poly-pharmacy and prescribing practices and documentation
- Quality monitoring policies regarding pharmacy, medication management and prescribing practices
- Policies and procedures related to medical care and evaluation including a plan for providing inpatient medical services for the individuals served when indicated
- Discharge planning policies and plan for implementing discharge protocols of DMHMRSAS
- Plan for assessing quality and completeness of discharge planning
- Parameters for review of individual cases with extensive use of S/R. Include recent documentation of utilization rates of seclusion and restraint at facilities currently operated by the organization
- Policies and proposed training programs for employees related to aggression management of persons served

- Evidence of experience serving persons with dual diagnoses such as mental health/ mental retardation or mental health/substance abuse
- Policies and procedures regarding utilization management and recent examples of utilization data
- Description of medical record, manual or electronic, that will be used to document patients' treatment from admission to discharge and evidence that the medical record meets CMS and JCAHO requirements and timeframes

**d. Organization of Health Care Service Delivery:**

- Documentation of the organizational chart and relationship to health system if applicable
- Policies and procedures related to the organization's management of professional practice including, privileges and credentialing, methods of clinical pertinence, and standards of documentation of professional practice in medical records
- Policies and procedures related to the organization's method of considering and assuring review of bioethical issues.
- Policies and procedures for the use of clinical information in organizational performance.

**e. Quality Improvement, Risk Management and External Reviews:**

- Policies and procedures related to the quality improvement program
- Risk management policies and procedures including process for review of critical incidents
- Current risk management statistics and examples of corrective actions taken
- Documentation of cooperation with patient advocacy groups, state oversight offices and any other oversight organizations

**f. Utilization Management:**

- Policies and procedures in place related to: evaluating medical necessity for admission; evaluating the cost and quality of services; detecting over and under utilization of services; assuring appropriate access to services.

**2. Questions to be Answered by the Organization Submitting Proposal:**

a. How will your organization provide the necessary assessments, evaluations and treatment to the diverse population served including the forensic population and the dually diagnosed population?

b. How will your organization coordinate discharge and aftercare with the appropriate community services board and/ or private providers?

c. What special procedures will be implemented to handle patients that have discharge barriers?

d. How will your organization coordinate internal risk management plans with the DMHMRSAS and state risk reporting requirements?

e. How will your organization ensure compliance with requirements of the criminal justice system as it relates to forensic review, evaluation and treatment of people served currently by state facilities?

f. How will your organization assess the effectiveness of the psychosocial programming and assure that the people served are receiving services related to their reasons for admission?

g. How will your organization integrate the principles of recovery and self-determination into all aspects of programming?

h. How has your organization handled any regulatory or oversight sanctions in facilities that you currently own or operate?

i. How will your organization submit data to the Department concerning utilization management?

**C. Support Services**

**1. Materials to be Provided with Each Proposal:** The organization submitting a proposal shall include the following materials with the proposal:

a. Policies and procedures concerning food service provision and delivery and plan for assuring compliance with all regulatory agencies
b. Quality monitors to assure safety and regulatory compliance
c. Policies and procedures concerning laundry services or Memorandum of Agreement (MOA) with laundry service to show services provided and plan for compliance with regulatory agencies.
d. Policies and procedures for personal laundry of the people served
e. Policies and procedures for building and grounds maintenance or MOA with contracted sources showing services provided
f. Policies and procedures for security provision or MOA showing security services provided and a plan for internal security for forensic units and/or clients
g. Policies and procedures for transportation of people served to medical appointments, court hearings, hospital etc. including security measures for forensic clients
h. Policies and procedures related to housekeeping services

**2. Questions to be Answered by the Organization Submitting Proposal:**

a. How will the organization assure compliance with all regulatory requirements regarding food service?

b. How will the organization show compliance of the MOA partners regarding regulatory requirements?
c. How will the organization evaluate security needs and effectiveness?
d. How will the organization assure adequate infection control measures for the facility?

**D. Human Resources**

**1. Materials to be Provided with Each Proposal.** The organization submitting a proposal shall include the following materials with the proposal.

a. A copy of the proposed organizational structure and staffing by shift for the new facility or facilities at the time of acquisition. This should be done in detail by discipline; for example, the number of RNs, LPNs and direct service workers to provide nursing services; the number of psychologists with Bachelors, Masters and Doctoral degrees to provide psychological services; the number of physicians designated by specialty; the number of rehabilitation staff such as occupational therapists, certified occupational therapy assistants (COTAs), physical therapists, recreational therapists, speech therapists, music therapists and any other therapists; the number of social workers with Bachelors and Masters degrees and the number of licensed clinical social workers. In addition, the organization shall submit a plan for compliance with the Commonwealth of Virginia Office of Professional Licensure Standards.

b. The organization shall document the staffing plan by ward and by shift, including the total number of employees proposed for employment from existing state facilities at the time of acquisition. The organization shall identify how many employees will be full-time, part-time, and/or contractual at the time of acquisition and after one year.

c. Loss claims statistical information from the organization's insurance carrier for workers compensation for the past 3 years for any mental health, mental retardation facilities currently owned or operated. If none are currently owned or operated, the organization shall provide this information for any health care facility, or other type of facility currently owned or operated.

d. Turnover data by job type for the past 3 years for any mental health or mental retardation facilities currently owned or operated. Turnover is defined as the number of separations divided by the average number of filled positions over one year.

e. A copy of the organization's dispute resolution policies/practices. The organization shall provide dispute resolution/mediation/arbitration statistics and trend data for past 3 years for any mental health or mental retardation facilities that are currently owned or operated by the organization. The number of employee disputes resolved in favor of employees or management shall be

provided and the number modified (those partial for employee and management); percentage or number resolved by management, and percentage/number resolved through court or other external ruling.

f. The number of EEO claims filed by employees out of the total number of employees; the number of cases found in favor of complainants, and the number found in favor of management.

g. The most recent "Employee Satisfaction Survey(s)" from the mental health/mental retardation facilities that the organization operates or has acquired.

h. A copy of the organization's Human Resources and Workforce Development Policies.

i. A copy of the organization's salary plan, including any non-base pay supplements. The Plan should show salary ranges/bands, and classifications of employees allocated to each of the ranges/bands and fringe benefits.

j. A copy of the job descriptions for direct care and support positions including qualification requirements.

k. Descriptions of all fringe benefits provided to employees. This shall include premium costs, co-payments, deductibles and restrictions on access to the benefits.

l. A description of the employee assistance program available to employees.

m. A copy of the paid time off program for employees. This shall include holidays, annual leave and sick leave / disability leave and any other forms of leave, such as educational or civil leave for jury duty or to respond to a summons.

n. A description of the organization's employee recognition program.

o. A description of the employee suggestion program.

p. A description of the performance management program and any associated forms.

q. A copy of the flexible benefits programs available to employees.

r. A copy of the overtime policy for mandatory and/or voluntary overtime.

s. A copy of the inclement weather policy.

t. The anticipated number of jobs created by the proposed project, approximate wage rates that will be paid, and projected length of employment of the newly created jobs.

u. The approximate number of job training opportunities created by the project, particularly in apprenticeship programs registered with the U.S. Department of Labor or State Apprenticeship Council.

v. Worker safety programs, including substance abuse programs, safety training, and incident avoidance programs.

w. Plans proposed to ensure that jobs created by the project will be filled by trained, qualified personnel.

x. The extent to which identified job opportunities will be made available and/or filled by residents of the Commonwealth.

y. The extent to which the project will utilize contractors and subcontractors who will generate tax revenue for the Commonwealth.

z. Plans for an Employee Health Program, including ergonomic assessments.

**2. Questions to be Answered by the Organization Submitting a Proposal**

a. At the time of transition, what will become of the existing staff members? Please see note below.

b. Will employees who are retained in their same capacity be paid the same salary as they were paid before the transition? If for a specified period of time, what is the time period?

c. What assistance will your organization provide to any employees who are not retained or who are laid off at a later time? What severance benefits will you provide? What Outplacement services will you provide for the employees?

d. How will you manage the transition of responsibilities?

e. What training will your employees be offered and which employees will receive it?

f. How will your organization assure adequate staffing levels , particularly for registered nurses and other professional staff?

g. How will you handle staffing during weather emergencies?

h. How will you survey the satisfaction of your employees?

i. What is your policy on alcohol and drug use by employees?

j. What is your policy for violence in the workplace?

k. What is your policy on sexual harassment?

**Note:** When the Medical College of Virginia Hospital converted to an Authority, employees were given 180 days notice that their positions would be transferred. If they elected to not go to the Authority, they were eligible for the State's severance benefits. If they elected to remain as employees of the Authority they were able to remain as members of the Virginia Retirement System or to move their retirement accumulations to the Authority's retirement plan. They were able to retain coverage in the State's healthcare plan or to take the Authority's. The Authority was required to develop a grievance procedure that was reviewed by the House Appropriations and Senate Finance Committees of the Virginia General Assembly.

Currently, the Virginia Information Technology Agency (VITA) is negotiating a PPEA proposal and has stated the following conditions for its potential partners:

- A potential partner must ensure VITA employees are treated fairly.
- No mass layoffs. Reductions in force will be managed through attrition, vacancies, retirement, etc.
- Employees must receive comparable (or better) employment packages, including salary, benefits, career development and training.
- Employees who perform work that is in-scope to the agreement will receive an employment offer from the partner.
- Employees who receive these offers have the choice of accepting them or remaining an employee of the Commonwealth of Virginia.
- If they remain state employees, they will continue to do the same or similar work and receive technical direction from the partner.

State employees who are involuntarily separated from state service will be entitled to the State's Severance Payments, which run from 4 to 36 weeks of pay, depending on the length of service, paying the agency cost of health and life insurance for one year and Unemployment Insurance for up to 12 to 26 weeks. The acquiring company will be responsible for reimbursing DMHMRSAS for these costs.

## E. Infrastructure Development and Maintenance

DMHMRSAS shall provide the organization submitting a proposal with an inventory of the buildings, equipment and services provided by the affected facility, including spaces leased to outside entities.

**1. Materials to be Provided with Each Proposal:** The organization submitting a proposal shall include the following materials with the proposal:

a. Environment of Care (JCAHO) management plans and programs for the referenced facility or for a comparable facility now operated by the offerer, to include the following:
   - Safety Management Plan
   - Patient Safety Program
   - Security Management Plan
   - Hazardous Materials Management Plan
   - Emergency Management Plan
   - Fire Prevention Management Plan
   - Medical Equipment Management Plan
   - Utility Management Plan
   - Risk Management Plan

b. Facilities management service program plans to include the following:

   - Operating, maintenance and repair objectives;
   - Building maintenance and repair management plan;
   - Emergency/disaster operating plan;
   - Safety program;
   - Quality control programs for support services;
   - Grounds maintenance operating plan;
   - Inclement weather operating plan;
   - Monthly report formats for support services, with sample reports;
   - Utility and energy management programs;
   - Plan for adherence to the Virginia Uniform Statewide Building Code, the Life Safety Code, and any other applicable codes and regulations; and
   - Management or disposition of vacant buildings.
   -
   - Quality assurance/quality improvement programs for all support services that will exist in the referenced facility. Include samples of standard tools and results for the measurement of satisfaction of clients, families and staff.

c. Plan for compliance with the Governor's Executive Order 29 regarding procurement regulations governing Small, Women-owned and Minority-owned (SWAM) businesses, including participation goals and methods of increasing

participation by SWAM businesses and for any other requirement included in the Governor's Performance Management Standards.

d. Building, infrastructure, and equipment repair, replacement and improvement plans and policies.

e. Plan for the proposed facility's participation in local or regional government disaster preparedness and support operations.

f. A description of the support services management and organizational structure, including the following information:

- Qualifications for on-site support services management personnel;
- Off-site management staff and support provided; and
- How training, annual re-training, and maintenance of staff certifications and competency are managed.

g. Identify which support services are planned for provision by in-house and which are planned for provision by contract.

- For in-house services: provide staffing by trades and licensure, and training plan and policies
- For contractual services provide plan and goals for utilization of local businesses and personnel, including impact on local economy.

h. Provide description of current or proposed technology solutions to meet the needs of business and clinical processes. (For instance, electronic medical records, financial systems, etc.)

i. Provide description of actual or proposed technical infrastructure.

j. Describe the system architecture; servers, hubs, switches, work stations and access nodes within each facility on a separate diagram. Then supply DMHMRSAS with a system architecture required by your company for IT continuity across all points. Illustrate licensure requirements at their most economical points of access, i.e., Enterprise, server, individual user levels and recommended procurement / deployment strategy proposed to maintain data access and security.

k. Provide a copy of the transition plan to be implemented should you be awarded this contract.

l. For a comparable facility, provide copies of your most current inspections by regulatory and oversight agencies and organizations, and the resultant plans of correction. Inspection reports shall include, but are not limited to, the following:

- Department of Health
- Center for Medicare/Medicaid Services

- EPA
- Fire Marshal and Building Code Inspections
- OSHA
- JCAHO

**2. Questions to be Answered by the Organization Submitting a Proposal**

a. Support of other facilities, agencies and political subdivisions includes consumer transfer arrangements' internships, disaster support, property leases and maintenance, and shared programs. How do you propose to develop and maintain these relationships?
b. If awarded a contract, how do you propose handling the transfer of functions and responsibilities, including existing contractual relationships?

c. How will you manage building and equipment maintenance? Provide examples of software, logs, plans and documentation of strategy for assuring continual fitness for duty across these categories of assets.

d. How would you address renewal and replacement of buildings, improvements and equipment? Do you have a re-commissioning strategy for buildings, utility systems and other support assets? If so, please share samples.

e. How do you handle environmental or hazardous material exposure or spill events?

f. How do you handle safety related incidents?

g. What actions will your organization take to help with integration into the community?

h. What is your organization's philosophy on security?

- Within the facility;
- Access to the facility; and
- The facility perimeter.

i. What is your plan and philosophy for handling community relations surrounding both positive and negative events requiring interface with citizens, the community, businesses, families, media and government?

j. What methods do you use to assure that systems and data are secure, including HIPAA compliance?

k. How do you promote effective communication and responsiveness between support services and the people served?

l. How do you respond to an issue that poses a safety or high risk to the clients, staff or operations?

m. How do you pro-actively identify conditions that may present a safety or high risk to clients, staff or operations?

n. What are your contingency plans for the loss of major systems or an operational outage?

o. What tools and processes would you use to maintain the on-going quality and viability of any public-private partnership that results from this proposal?

p. How would you provide data to DMHMRSAS to meet the agency's data requirements? Would you intend to become licensed users of existing DMHMRSAS applications?

q. How do you envision your staff and operations will require support from DMHMRSAS in regard to IT infrastructure?

**F. Fiscal (Cost, Financial Feasibility, and Revenue Impact)**

As noted earlier in this report, the Commonwealth of Virginia Procedures for the *Public-Private Educational Facilities and Infrastructure Act of 2002* contains suggested formats for conceptual stage (phase 1) and detailed stage (phase 2) submissions. Conceptual stage items that are recommended in the PPEA procedures that are fiscal-related are identified below in italics. These items are reiterated here to ensure that they are submitted with any proposal directed to DMHMRSAS.

**1. Materials to be Provided with Each Proposal:** The organization submitting a proposal shall include the following materials with the proposal:

a. Audited Annual Financial Report (*current or most recently audited financial statement of the firm or firms and each partner with an equity interest of twenty percent or greater).*
b. Credit rating and stock prices (last 5 years).
c. History of fraud and litigation (last 5 years).
d. Corporate structure and ownership including date formed.
e. *Identify the legal structure of the firm or consortium of firms making the proposal).*
f. *Identify the organizational structure for the project, the management approach and how each partner and major subcontractor ($1 million or more) in the structure fits into the overall team.*
g. Summary of similar projects related to the operation and maintenance of mental health facilities (include reference information). *Describe the experience of the firm or consortium of firms making the proposal and the key principals involved in the proposed project including experience with projects of comparable size and complexity. Describe the length of time in business, business experience, public sector experience and other engagements of the firm or consortium of firms. Describe the past safety performance record and current safety capabilities of the firm or consortium of firms. Describe the past technical performance history on recent projects of comparable size and complexity, including disclosure of any legal claims. Include the identity of any firms that will*

*provide design, construction and completion guarantees and warranties and a description of such guarantees and warranties.*

h. *For each firm or major subcontractor ($1 million or more) that will be utilized in the project, provide a statement listing all of the firm 's prior projects and clients for the past three years and contact information for same (names/addresses/telephone numbers/e-mail addresses). If a firm has worked on more than ten projects during this period, it may limit its prior project list to ten, but shall first include all projects similar in scope and size to the proposed project and, second, it shall include as many of its most recent projects as possible. Each firm or major subcontractor shall be required to submit all performance evaluation reports or other documents, which are in its possession evaluating the firm 's performance during the preceding three years in terms of cost, quality, schedule, maintenance, safety and other matters relevant to the successful project development, operation, and completion.*

i. *Identify any persons known to the organization presenting a proposal who would be obligated to disqualify himself from participation in any transaction arising from or in connection to the project pursuant to The Virginia State and Local Government Conflicts of Interest Act, Chapter 31 (§ 2.2-3100 et. seq.) of Title 2.2 of the Code of Virginia.*

j. *Provide information on the level of commitment by the firm or consortium of firms to use Department of Minority Business Enterprise firms in developing and implementing the project.*

k. A list of competitors who have similar capability.

l. Financing organization (s)

m. The proposal shall include the following information on project financing:

- *A preliminary estimate and estimating methodology of the cost of the work by phase, segment, or both.*
- *A plan for the development, financing and operation of the project showing the anticipated schedule on which funds will be required. Describe the anticipated costs of and proposed sources and uses for such funds. Include any supporting due diligence studies, analyses or reports.*
- *A list and discussion of assumptions underlying all major elements of the plan.*
- *Risk factors and methods for dealing with these factors.*

*n. Identify any local, state or federal resources that the organization submitting a proposal contemplates requesting for the project. Describe the total commitment, if any, expected from governmental sources and the timing of any anticipated commitment.*

*o.* The proposal shall include the following cost information (separate total cost calculations for):

- Building and operating the facility
- Building only
- Financing costs for building
- Operating cost savings with a new building or buildings
- Annual maintenance costs
- Costs per day-operating and capital
- Cost implications of failure to operate/open facility on time
- Assumptions used for cost increases each year (escalations)
- Costs assumed related to state employees transitioning to the private sector

p. The proposal shall include the following revenue (funding) information:

- Third-party funding sources
- Proposed collections from third parties
- Percentage of state general funds that will be required to operate the facility
- Description of the billing and collection function

q. Proposals shall include the following information on project benefit and compatibility.

- *Identify community benefits, including the economic impact the project will have on the Commonwealth and local community in terms of amount of tax revenue to be generated for the Commonwealth and political subdivisions, the number of jobs generated for Virginia residents and level of pay and fringe benefits of such jobs, the training opportunities for apprenticeships and other training programs generated by the project and the number and value of subcontracts generated for Virginia subcontractors.*
- *Identify any anticipated public support or opposition, as well as any anticipated government support or opposition, for the project.*
- *Explain the strategy and plan that will be carried out to involve and inform the general public, business community, local governments, governmental agencies in areas affected by the project,* and stakeholders, such as patients and their families.
- *Describe the compatibility of the project with local, regional, and state economic development efforts.*
- *Describe the compatibility with the local comprehensive plan, local infrastructure development plans, and any capital improvements budget or other government spending plan.*

r. Ten-year projection comparing costs of the proposed structure with the current structure of the facility.

s. Electronic files for cost and revenue projections included in the proposal.

**2. Questions to be Answered by the Organization Submitting a Proposal**

**a.** How can information presented in the proposal be independently verified?

**b.** If errors are found or corrections are required in your cost or revenue projections, how quickly can the organization make changes and return the proposal to the agency?

**c.** How will you limit operating cost increases?

d. Will your organization permit the DMHMRSAS audit organization to review your proposal documentation, supporting records, and interview your staff?

## II. REQUIRED DELIVERABLES

A. Required documents specified in Evaluation Criteria

B. Answers to the questions specified in Evaluation Criteria

C. The proposal

D. References from entities with which the organization submitting a proposal has had contractual agreements for providing the same type of service. (References shall include information from at least three Facility Owners with whom the organization submitting a proposal has or has had a contract to provide comparable

services.) Information provided shall include name and address of the facility, name of contact person and position held, telephone number and e-mail address

E. Names, addresses and telephone numbers of persons within the organization submitting the proposal or consortium of organizations submitting a proposal who may be contacted for further information

## III. DMHMRSAS CRITERIA FOR PROPOSAL REVIEW

A. Completeness,
B. Organization of Proposal
C. Responsiveness,
D. Cost effectiveness,
E. Integration of operations with local jurisdictions, community service providers, and private acute care hospitals
F. Comparison of policies, procedures and practices to best practices in the field
G. Thoroughness of policies and procedures
H. Compatibility with Agency and Facility Policies and Requirements
I. Evidence of quality management monitors
J. Evidence of proposed adequate staffing meeting necessary competencies
K. Evidence that staffing, policies, and procedures demonstrate that treatment elements of assessment, planning, medications management, PSR, behavioral services, and milieu are integrated to provide safe and individualized treatment plans
L. Sensitivity to existing employees
M. Evidence of understanding of the needs and requirements of the Commonwealth
N. Evidence of experience in forensic services, dual diagnosis and medical co-morbidity (if applicable)
O. Evidence of JCAHO accreditation and/or CMS certification and other relevant national accreditations or certifications
P. Community involvement in the development of the proposal
Q. Consumer and family member involvement in the delivery of services under the proposal
R. References

In addition, DMHMRSAS will conduct an on-line search about the organization and inquire of local and state authorities in other states where the entity operates a similar service regarding specific questions about performance and compliance.

## APPENDIX B

The following organizations submitted the attached letters and correspondence in response to the Exposure Draft of the report:

A. **Southside Community Services Board, Executive Director, e-mail dated October 21, 2005**

B. **Colonial Services Board, Executive Director Memorandum, dated October 24, 2005**

C. **City of Virginia Beach, Mayors Office, letter dated October 25, 2005**

D. **Virginia Hospital and Healthcare Association, letter dated October 25, 2005**

E. **NAMI Virginia, letter dated October 26, 2005**

F. **Troutman Sanders Public Affairs Group LLC, letter dated October 27, 2005**

G. **City of Virginia Beach, Community Services Board, Chairman, letter dated October 27, 2005**

H. **Arlington Community Services Board, Executive Director, e-mail dated October 27, 2005**

I. **Fairfax-Falls Church Community Services Board, Executive Director, e-mail dated October 27, 2005**

J. **Liberty Healthcare Corporation, letter dated October 31, 2005**

## Mead, Martha

**From:** Jules Modlinski [jmodlinski@sscsb.org]
**Sent:** Friday, October 21, 2005 2:04 PM
**To:** Mead, Martha
**Subject:** Re: Secretary's PPEA Feasibility Study

Thank you. Have read the document and it appears that it pertains mostly to care given at a state level rather than local level. Not quite sure if the document includes the state facility in Danville, some of the state facilities, or all of the facilities. There is an option not presented in the document and that would involve a regional consortium of CSB's operating a state facility under contract with the Department. Given that we are not part of the state, but (as Howard Cullum used to say) are "instrumentalities of local government," it would appear quite feasible to me to include this arrangement as a possible "contractual manager" of a state facilities; or perhaps at the least to give such a consortium the option of submitting a proposal to operate a state facility.

Thanks for letting CSB's review the document. Good Luck!!

Jules Modlinski
Southside CSB

----- Original Message -----
**From:** Mead, Martha
**To:** 'Jules Modlinski'
**Sent:** Friday, October 21, 2005 12:04 PM
**Subject:** RE: Secretary's PPEA Feasibility Study

Here it is.

***Martha Mead, Director, Legislation and Public Relations***
***martha.mead@co.dmhmrsas.virginia.gov.***
***804-786-9048***

-----Original Message-----
**From:** Jules Modlinski [mailto:jmodlinski@sscsb.org]
**Sent:** Friday, October 21, 2005 12:14 PM
**To:** martha.mead@co.dmhmrsas.virginia.gov
**Subject:** Secretary's PPEA Feasibility Study

Martha: Would appreciate having the study emailed to me as indicated in Commissioner's email to CSB Exec's. Thanks.

Jules Modlinski
Email: jmodlinski@sscsb.org

Colonial Services Board
Mental Health, Mental Retardation, and Substance Abuse Services
SERVING JAMES CITY AND YORK COUNTIES, POQUOSON AND WILLIAMSBURG

MEMORANDUM

To: Martha Mead, Director
Legislation and Public Relations

From: Dennis I. Wool, Ph. D.
Executive Director

Re: Feasibility Exposure Draft

Date: October 24, 2005

---

Thank you for the opportunity to comment on the exposure draft. As noted in the session held last week, I believe the most important aspect of this draft is its ability to communicate the role of the public psychiatric hospital in a continuum of essential governmental services. This places the hospital on the same planning field as police, fire, rescue, public health sanitarians, adult and child protective services. The core of responsibility rests with the State as a matter of practice for more than three centuries and should not be tampered with to expedite the construction of new hospital facilities. No jurisdiction within the Commonwealth would consider such privatization for its acute care needs essential to the public safety – no less; the State should not abdicate its responsibilities to its most vulnerable citizens.

While the project may require some editing to meet the expectations of both the Secretary and the audience of the Legislative Committees, the principles outlined under **V. Public Policy Issues for Virginia** masterfully articulate the areas which must be reviewed by the Legislative Committees. It is the view of this office that a viable behavioral health response system can only be sustained through the partnerships that honor their commitments. Recent events suggest that the Department and the Legislature have invested in enhancing the functionality of Regional Hospital/CSB relations resulting in greater access to care, more timely and appropriate care, and better consumer outcome. The introduction of a private hospital into the mix would require contracting skills at the highest levels, particularly if the goal is nothing more than private capitalization of new construction.

There is a great deal of information in the draft – my recommendation is that you focus on the nine issue points and provide sufficient data from your Executive Summary to capture the limited time available to the Legislative Committees.

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# City of Virginia Beach

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MAYOR

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October 25, 2005

James Reinhard, M.D.
Commissioner
Department of Mental Health, Mental Retardation
And Substance Abuse Services
P. O. Box 1797
Richmond, Virginia 23219

Dear Commissioner Reinhard:

First, I want to again thank you for participating in our Annual Walk For Hope on October 8, 2005. Despite the adverse weather, it was a wonderful event and I appreciate your traveling to Virginia Beach on a Saturday morning so that you could be part of our program.

However my major purpose in writing to you relates to the work your Department has been doing in developing a framework for the potential privatization of state psychiatric facilities in Virginia. Specifically I want to comment on the Exposure Draft of The Feasibility of Public-Private Eduational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities.

As the Mayor of the City of Virginia Beach, I want to express my deepest concerns regarding this issue. Because of my interest in mental health, I feel that I am well informed with regard to our local programming serving mentally ill adults in our community. In fact, I just spoke at a partnership event at Beach House on Thursday evening and again had the opportunity to directly talk with clients, family members, and staff. I have toured programs for years and sometimes have to respond to complaints from people unable to access services in a timely way given waiting lists.

I think it is a serious error in public policy to consider the privatization of an essential public service. Hospital services for the mentally ill are a public safety concern for communities across Virginia. We continue to see a very fragile group of people trying to live in our communities. When they do not receive the services they need, they pose a significant safety risk for the community and for themselves. Just today in national media is the story of the mentally ill woman in San Francisco who threw her three young children in the bay where they are now presumed dead. She is described as suffering from schizophrenia and refusing to take her medications. What service could be more essential than hospitalization for people who are this ill? I urge the Commonwealth to put aside considerations of privatizing state hospitals in Virginia. Localities, family members, and clients need to know that we can impact the quality of care of essential services to our highest risk citizens. Mental health is a core responsibility of government and public accountability must be maintained.

I appreciate the opportunity to comment on the Exposure Draft and want to be kept informed as to how this issue proceeds. If I can provide you additional information, please let me know.

Sincerely,

Meyera E. Oberndorf

Meyera E. Oberndorf
Mayor

Cc: Members of City Council
Members of the Virginia Beach Delegation
Virginia Beach Community Services Board
James Spore, City Manager
Susan Walston, Chief of Staff
Terry Jenkins, Director of Human Services

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060-6712
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

October 25, 2005

Ms. Martha Mead
Dept. of Mental Health, Mental Retardation and Substance Abuse Services
P.O. Box 1797
Richmond, VA 23219

Dear Ms. Mead:

Thank you for the opportunity to provide comments on the exposure draft titled *The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 Proposals for the Operation and Maintenance of Mental Health Facilities.*

In particular, you expressed interest in comments on the public policy issues that are outlined in the draft. As you know, private acute care hospitals work closely with the state's mental health system, and so we concur that one of the questions that must be addressed in the evaluation of any privatization proposal is the impact on "relationships with area community services boards, private providers, and providers of acute care."

We suggest that the public policy issue outlined in the first bullet on page 14 of the report be expanded to include the following:

- Will this affect the ability of private acute care hospitals to transfer patients to state facilities when such a transfer is the appropriate placement for the patient?
- Will the privatization of state facilities lead to a further reduction in the number of beds in those facilities?
- Will it affect the state service delivery system if some state facilities are operated under contract by a private provider while other state facilities continue to be operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services?

In addition, we suggest that Item E of the DMHMRSAS Criteria for Proposal Review (p. 36) be revised to read, "Integration of operations with local jurisdictions, community service providers *and private acute care hospitals.*"

Thank you again for including the Virginia Hospital & Healthcare Association in the evaluation of this draft. Please contact me if we can be of further assistance.

Sincerely,

Betty Long

Betty Long
Vice President

NAMI Virginia
The Nation's Voice on Mental Illness
**The National Alliance for the Mentally Ill**
**PO Box 1903, Richmond, VA 23218**
**804-426-6499**

October 26, 2005

The Honorable Jane Woods
Secretary of Health and Human Services
State of Virginia

Subject: "The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PEPA) Proposals for the Operation and Maintenance of Mental Health Facilities"

Dear Ms. Woods,

Thank you for the opportunity to review the captioned report. Two parts of the report are particularly troubling to NAMI-VA, they are: Section IV – "History of the Privatization of Mental Health Services", and Section V – "Public Policy Issues for Virginia." We will deal with the most significant first.

"Public policy Issues for Virginia": This section of the report was the only one we discussed during the Draft review meeting on October 20th. The drafters of the report rightfully assumed that the primary concerns of NAMI-VA, Community Service Boards and other to the privatization discussion would be:

> "The complex nature of the mental health services system includes in many cases the Involvement of local government, law enforcement, the judiciary, public and private treatment Professionals, human rights advocates, the legal community and consumer and advocacy organizations. Issues of appropriate treatment may also involve issues of public safety that must be dealt with by Communities and policy makers."
>
> "Contracting for services that are essential to fundamental purpose of government requires extreme caution. The Commonwealth can delegate authority for operation and maintenance, but not its responsibility to the citizens of Virginia".

NAMI-VA feels that the State Hospital System and particularly Eastern State with the Reinvestment process and Discharge Assistance Funding has made significant progress in recent years. Additional progress can be made with an adequate more efficient facility. We are very concerned that changing the culture in the hospital will negatively affect the progress made in recent years in Region V.

"History of the Privatization of Mental Health Services": This section and data from the internet on "Privatization of mental health facilities" paints a very negative picture of other states attempts at privatization. The captioned report did not provide any information comparing Florida's mental health delivery system verses Virginia's community based system. Are we comparing apples to apples, and would the delivery differences make the process workable in one state and not workable in another?

We recognize the exploration of alternative is a healthy process, but want assurance that NAMI-VA and other advocacy organizations will be involved early in the process when changes are proposed in the community based system Virginia is improving yearly.

Very truly yours,

Bill

H. W. Farrington
First Vice President

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File No. PAG125.000001

October 27, 2005

***BY HAND DELIVERY***

Ms. Martha Meade
Virginia Department of Mental Health,
Mental Retardation & Substance Abuse Services
1220 Bank Street
Richmond, Virginia 23219

Dear Martha:

In accordance with the instructions at the stakeholder meeting last Thursday, I am submitting these comments on behalf of Atlantic Shores Healthcare. Because of the short turnaround time and the effects of Hurricane Wilma on South Florida where Atlantic Shores is headquartered, my client has not been able to provide any detailed responses to the document. Currently, the corporate headquarters, as well as the residences of its senior officers are without power and communication. Nevertheless, we want to commend the work of the Work Group and staff on the draft study.

Preliminarily, to update the information on Atlantic Shores' operations in Florida, the company has recently been awarded a contract to reconstruct and operate the State's forensic mental health facility, South Florida Evaluation and Treatment Center, located in Miami, Florida. Much like the process at South Florida State Hospital, Atlantic Shores will operate the current facility while constructing a new one for the State.

Much of the exposure draft, and virtually all of the discussion at the stakeholder session, focused on the public policy issues associated with a privatization of operations. The public policy questions presented are important ones. Certainly, some level of analysis is required to determine whether the privatization of mental health facilities in Virginia serves the interest of the consumers, the Commonwealth and the public at large. Atlantic Shores believes

that its experience in Florida and the experience of the Commonwealth has in privatizing other critical governmental services such as adult incarceration, provide much of the information needed to answer these questions. Atlantic Shores looks forward to participating in a dialogue with the stakeholders and policymakers to address how Virginia's mental health system, which already includes significant private sector resources, can integrate additional privatization efforts to benefit the consumer as well as the Commonwealth.

One of the major areas of concern noted during the stakeholder discussion was that of the status of the Commonwealth's employees. The experience of Atlantic Shores in its Florida operation, as well as the Commonwealth's experience with regard to MCV and the recent VITA announcement, provides a roadmap by which the complex area of employee relations can be adequately navigated.

The appendix to the exposure draft presents a very helpful itemization of the issues that a proposer would need to present in order for the Department to make an intelligent decision regarding any potential PPEA proposal. As an operator of privatized facilities, Atlantic Shores has answered most of these questions before, but it is helpful to see the areas of concern held by facility directors, medical personnel and consumers. It is also instructive to see the concern for integrating the private facility elements of the system with the public ones. Both Atlantic Shores, and its corporate parent, the GEO Group, have substantial experience developing strong working relationships with public sector operations and look forward to responding to these concerns.

Atlantic Shores appreciates the opportunity to comment on the exposure draft and looks forward to working with the Commissioner and Secretary as the Commonwealth continues to look at the benefits of privatization.

Very truly yours,

Theodore R. Adams, III

#1410889v2

cc: Mr. Jorge A. Dominicis

City of Virginia Beach

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October 27, 2005

James Reinhard, M.D.
Commissioner
MH/MR/SA
P. O. Box 1797
Richmond, Virginia 23219

Dear Commissioner Reinhard:

I am writing in response to the Exposure Draft of The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities. Following a review of the report by Dr. Jenkins during this morning's Board meeting, the Board asked that I transmit this letter to you. I understand that Mayor Oberndorf has also sent you a letter expressing her concerns regarding the report.

We do not support the privatization of Eastern State Hospital since the services it provides are essential to the vulnerable persons in this region who receive care in the facility. We believe that it is important for consumers, family members, and the community at large to be confident in the quality of care provided through a system of public accountability. Given the mandated linkages between local and state government with regard to the delivery of services, it is also important for localities to know that the state government remains a partner in the delivery of services to the most vulnerable persons in our community. Consequently we ask that you transmit our recommendation that privatization efforts of the operation of state psychiatric facilities through the potential use of PPEA be discontinued.

Thank you for the opportunity to comment; we will want to track this issue closely and would appreciate updates from your office as this report moves forward. If I can provide additional information, please let me know.

Sincerely,

William R. Brown
Chairman

Cc: The Honorable Meyera E. Oberndorf
The Honorable Peter W. Schmidt
James K. Spore, City Manager
Susan Walston, Chief of Staff
Terry S. Jenkins, Ph.D., DHS Director
Community Services Board

## Mead, Martha

**From:** Robert Sharpe [Rsharpe@arlingtonva.us]

**Sent:** Thursday, October 27, 2005 5:26 PM

**To:** martha.mead@co.dmhmrsas.virginia.gov

**Cc:** Cindy Kemp; Patricia Carroll

**Subject:** Comments on PPEA Proposals for the Operation and Maintenance of Mental Health Facilities from Arlington CSB, Dept. of Human Services

Dear Ms. Mead,

Following are stakeholder comments from Arlington Community Service Board Executive Director Cynthia Kemp on the Exposure Draft entitled "PPEA Proposals for the Operation and Maintenance of Mental Health Facilities." Ms. Kemp also represents the Arlington County Department of Human Services in her capacity as Division Chief of Behavioral Healthcare.

*I am opposed to the privatization of the state mental health facilities. Even though there is a philosophy out there that public services should only provide services for which there is no private provider, I do not think that anyone should be making a profit from serving people in the safety net. There must be a direct, accountable, state system responsible for the care of these very ill individuals. These are indigent, disenfranchised people who need to have well coordinated, quality service. If they are not served well, they will end up in the jails and on the streets in greater numbers than is happening now. In my opinion, it does not save the system money nor serve the person better to privatize the state facilities. I am concerned that a private provider would focus on saving dollars and maximizing profits and not on the recovery on seriously mentally ill people.*

*It appears that the PPEA provides for some contractual protections that ensure that the community services are well supported and the stipulations for private providers seem quite high – which is good. It is my understanding that the state was under some pressure to produce the document and all in all they did a decent job with a challenging assignment.*

Please let me know if you want more information. Cindy

***Cynthia L. Kemp***
Executive Director of the Arlington Community Services Board
and Division Chief of Behavioral Healthcare
1725 N. George Mason Dr.
Arlington, VA 22205
(703) 228-4843

c/o
Robert Sharpe
Assistant to the Directors
Department of Human Services
3033 Wilson Blvd, Suite 700A
Arlington, VA 22201
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**Mead, Martha**

**From:** Thur, James A. [James.THUR2@fairfaxcounty.gov]
**Sent:** Thursday, October 27, 2005 4:19 PM
**To:** martha.mead@co.dmhmrsas.virginia.gov
**Cc:** vacsb - Mary Ann
**Subject:** State MH Facility PPEA

I am submitting the following comments on the Exposure Draft on The Feasibility of Public-Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities.

- It appears that the PPEA Review Criteria are set up with only **existing, private** corporations in mind. The criteria should be amended to allow **newly established, public** corporations to also submit proposals.
- Section, F.1.r. of the Evaluation Process Criteria (p.35), requests a "six-year projection comparing costs..." Given the complexity, scope and size of these endeavors, it is recommended that the projection period be increased to **ten years**.

Thank you for this opportunity to comment.

James A. Thur, MSW, MPH
Executive Director
Fairfax-Falls Church Community Services Board

Liberty Healthcare Corporation

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October 31, 2005

Ms. Martha Mead
Department of Mental Health, Mental Retardation
and Substance Abuse Services
P.O. Box 1797
Richmond, VA 23219

Dear Ms. Mead:

We appreciate being invited to attend the meeting last week in order to comment on the exposure draft report entitled, "The Feasibility of Public Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities." Liberty Healthcare wants to take this opportunity to clarify, in writing, some information contained in the report in Part I of this letter and wants to reiterate its commitment to the Commonwealth of Virginia in Part II.

## PART I.

Page 13: The report states that "*DMHMRSAS evaluated the cost-effectiveness of services provided by Liberty... and concluded that significant cost-savings and administrative efficiencies could be realized by terminating the contract.*"

This statement implies that Liberty was too expensive. It should state that the DMHMRSAS evaluated the cost-effectiveness of maintaining a satellite unit that required a large rent payment to Riverside Jail and additional contract services. We maintain that Liberty was quite cost-effective based on the following facts. First, the DMHMRSAS issued a second RFP in the Fall of 2002 to continue the Riverside contract and selected Liberty for a second time over the other vendors. This would certainly indicate that Liberty could not have been significantly more costly than the other competitors, which included Atlantic Shores. In fact, when the cost for renting the unit from Riverside Jail is subtracted from the per diem, Liberty's program was cheaper than the state hospital. Moreover, Liberty's program was shown to be more efficient in terms of shorter lengths of stay and more patients served per available bed (see attached report to the Department).

Finally, the report fails to take into account the situation that necessitated the creation of a satellite unit for Central State Hospital and the situation that resulted in its closure:

> *The first Riverside RFP*: Nine organizations attended a pre-proposal conference in 1996 for the initial RFP to create and operate a forensic psychiatric facility within Riverside jail. The RFP required the vendor to start from scratch to open the new program with a

full complement of staff and obtain preliminary facility licensure to accept patients within four to six weeks. Although Liberty was the only company to respond to the RFP, *Liberty was the only organization with the expertise and ability who could successfully achieve this extraordinarily difficult task.*

When any emergency crises promulgated by a DOJ action occurs, such as the one experienced at Central State Hospital, a state like Virginia has to spend money to correct the situation. The issue is whether the money was spent wisely to address the crisis. In the end, the Commonwealth recognized that the Riverside project was able to fully correct the DOJ actions, enhance the level and quality of services provided to consumers while reducing lengths of stay.

Under Liberty Healthcare's management the Riverside program became fully accredited by the JCAHO and earned the reputation for delivering outstanding clinical services, while receiving accolades from the Department, Central State Hospital, attorneys, judges, law enforcement officials, community service boards, NAMI and other constituents throughout the Commonwealth.

*The second Riverside RFP*: After Liberty operated the program for the initial contract period, the DMHMRSAS issued a second RFP in the Summer of 2002. At this time, several companies expressed interest in the Riverside project and actually submitted proposals, including Atlantic Shores Healthcare. Once again, the Commonwealth selected Liberty Healthcare in a competitive process, obviously showing that Liberty offered the best combination of quality, competency and cost-effectiveness. Unfortunately, the State fiscal crises drove the decision to close the Riverside program shortly after the Department's selection of Liberty.

Liberty Healthcare trusts that this letter will rectify the misinformation cited in the report, "The Feasibility of Public Private Educational Facilities and Infrastructure Act of 2002 (PPEA) Proposals for the Operation and Maintenance of Mental Health Facilities."

## Part II.

Beyond the correction of errors in the draft report, Liberty wishes to reiterate its strong interest in serving the Commonwealth of Virginia in future projects. We are especially interested in submitting PPEAs and responses to any RFPs that entail the possible privatization of state operated programs. Our organization embraces the Commonwealth's Integrated Strategic Plan's vision statement. The guiding principals are commendable and reflect the desire of the DMHMRSAS and other Commonwealth stakeholders to move the present institutional system to a less restrictive, consumer choice driven one.

Liberty Healthcare has over twenty-five years of exemplary experience providing a broad range of contract clinical and administrative services to state mental health, developmental disabilities and juvenile agencies. Over half the states in the country have engaged Liberty to meet their contract needs whether it is physician and other health care professional staffing or facility management.

The company also provides turn key operations to meet the ever-growing needs for specialized programs for challenging populations including sexually violent predators and dually diagnosed MH/MR consumers.

Likewise, Liberty Healthcare has been at the forefront of working with state agencies in downsizing state facilities and moving consumers back to their communities. The organization has worked collaboratively with all stakeholders (consumers, state employees, community providers, etc.) so that costly operated state institutions can be right sized, freeing up money for less expensive community services. This option can be successful with state operated developmental centers as well as with psychiatric hospitals.

Thank you again for correcting the errors in the report and for allowing us to reiterate our commitment to the Commonwealth. If you have any further questions or desire more information, please call me.

Sincerely,

Tom Boshell
Senior Vice President

TB/gc

cc: The Honorable Jane H. Woods, Secretary of Health and Human Services
James S. Reinhard, M.D., Commissioner, DMHMRSAS