DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Item 314 E. – Report:

Northern Virginia Training Center Diversion Pilot

To the Chairs of the House Appropriations and Senate Finance Committees

November 1, 2010

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November 1, 2010

The Honorable Charles J. Colgan, Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Colgan:

Pursuant Item 314.E. of the *Appropriation Act*, enclosed is the report on the diversion project to serve individuals in the community who otherwise might be admitted to Northern Virginia Training Center (NVTC). The report includes a review of evidence-based community services that have proven cost effective in reducing the demand for placement at NVTC or other similar facilities.

Thank you for the opportunity to present this information to you. If you have any questions, please feel free to contact me.

Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon. R. Edward Houck
Joe Flores
John Pezzoli
Janet Lung
Ruth Anne Walker

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November 1, 2010

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Putney:

Pursuant Item 314.E. of the *Appropriation Act*, enclosed is the report on the diversion project to serve individuals in the community who otherwise might be admitted to Northern Virginia Training Center (NVTC). The report includes a review of evidence-based community services that have proven cost effective in reducing the demand for placement at NVTC or other similar facilities.

Thank you for the opportunity to present this information to you. If you have any questions, please feel free to contact me.

Sincerely,

James W. Stewart, III

Enc.
Cc: Hon. William A. Hazel Jr., M.D.
Hon Harvey B. Morgan
Susan Massart
John Pezzoli
Janet Lung
Ruth Anne Walker

Item 314 E. – Northern Virginia Training Center Diversion Pilot

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Item 314 E. – Northern Virginia Training Center Diversion Pilot

EXECUTIVE SUMMARY

The 2010 General Assembly tasked the Department of Behavioral Health and Developmental Services (DBHDS) with establishing a pilot to divert admissions to the Northern Virginia Training Center (NVTC). NVTC is a 170 bed, state-operated intermediate care facility (ICF) that provides medical and habilitative services to individuals with intellectual disabilities. The individuals that reside at NVTC receive long-term medical and habilitative care 24 hours a day from direct support and other medical professionals. The budget amendment proposing the pilot states:

"The Commissioner, in cooperation with the Virginia Association of Community Services Boards and the Northern Virginia Training Center (NVTC), shall develop a pilot project to serve individuals in the community who otherwise might be admitted to NVTC. The pilot shall include a review of evidence-based community services that have proven cost effective in reducing the demand for placement at NVTC or other similar facilities. The pilot project shall have no effect on the status of individuals currently residing at NVTC. The Commissioner shall report his findings and recommendations to the Chairmen of the Senate Finance and House Appropriations Committees by November 1, 2010."[Item 314 E.]

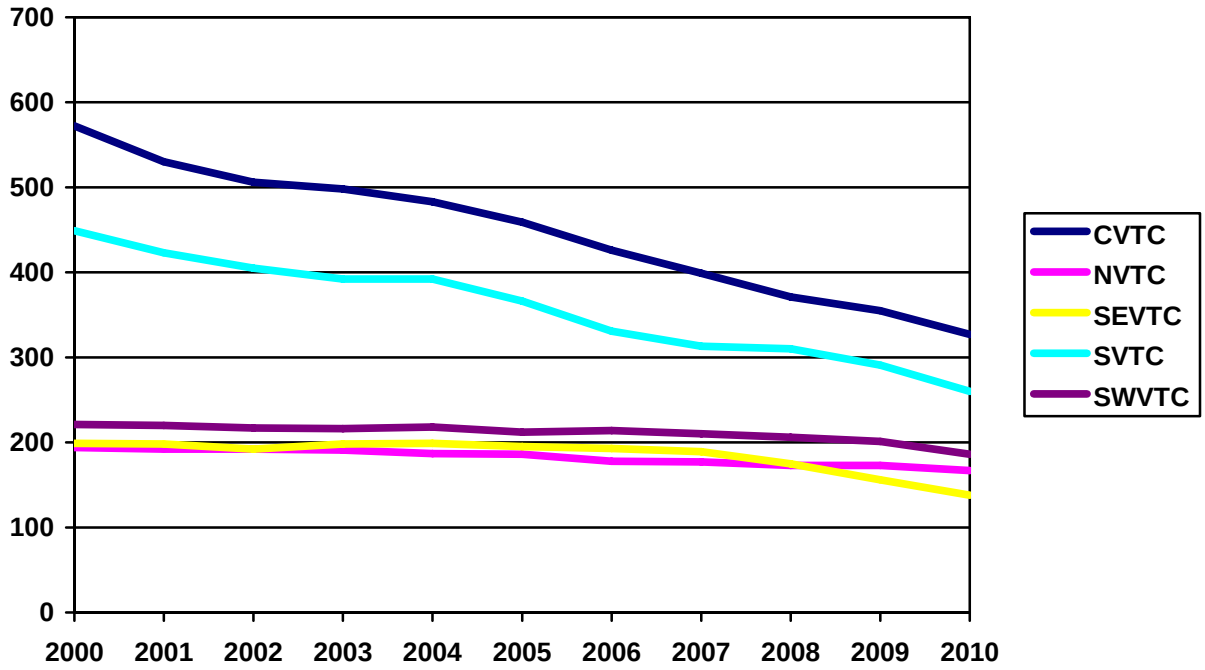
DBHDS brought together the Director of NVTC, other DBHDS staff, and the Community Services Boards (CSB) Intellectual Disability (ID) Directors from Health Planning Region 2 to evaluate current practices that are diverting admissions from NVTC and discuss the additional options that may further reduce the need for long-term admissions to the training center. The CSB Intellectual Disability (ID) Directors are responsible for the coordination of care for individuals with intellectual disabilities in their CSB catchment area whether they reside in the community or in a facility like NVTC. Health Planning Region 2 encompasses Arlington, Fairfax, Prince William, Loudoun Counties, and the Cities of Alexandria, Fairfax, Fall Church, Manassas, and Manassas Park.

This report reflects the information, data, and consensus of DBHDS staff and the Region 2 ID Directors. The report outlines the current status of admissions and discharges to NVTC and Virginia's four other training centers, current practices that the Region employs to divert admissions from NVTC, and options for implementing additional activities to further divert admissions to NVTC.

I. Admissions and Discharge Trends at Virginia's Five Training Centers

Over the last ten years, training centers have seen a significant drop in overall census from 1635 residents in FY2000 to less than 1100 today (Figure 1). NVTC's census has declined from 194 residents in FY2000 to 163 residents by June 30, 2011. This overall decline in census is the result of two complementary trends. First, more individuals are choosing to leave training centers and move to group homes, community intermediate care facilities (ICFs), or other settings. Over the last five years, 498 individuals have moved from Virginia's training centers to one of these community settings or died.

Figure 1: Annual Census at Virginia's Training Centers



Central Virginia Training Center (CVTC), Northern Virginia Training Center (NVTC), Southeastern Virginia Training Center (SEVTC), Southside Virginia Training Center (SVTC) and Southwestern Virginia Training Center (SWVTC).

The second complementary trend has been the virtual elimination of long-term, regular admissions to training centers. Long-term, regular admissions are those extending more than 75 days.[1] Since 2005, there has been an average of 16 long-term, regular admissions per year for all five training centers. Table 1 shows the annual trend for each training center. It is clear from the data that increasingly fewer individuals and families are choosing training centers as a long-term care option. The data also clearly shows that CSBs and training center directors are working closely together to prevent admissions to training centers whenever possible and are finding community options as alternatives to institutional care. The approaches used to reduce these admissions are discussed in the next section.

Table 1: Number of Long-Term Regular Admissions to Training Centers

End of FY	CVTC	NVTC	SVTC	SEVTC	SWVTC	TOTAL
2005	7	3	8	3	6	27
2006	3	2	7	3	5	20
2007	6	3	2	3	1	15
2008	4	2	5	0	4	15

[1] 12VAC35-190-10-51. Regulations for Admissions to Training Centers.

2009	3	4	2	0	3	12
2010	1	3	2	1	1	8
Average/Yr	4	3	4	2	3	16

Training centers continue to admit individuals requiring respite care for less than 21 days or emergency care for less than 75 days.[2] According to recent DBHDS data, there was an average of 40 emergency admissions to each training center each year for the last six years and 62 respite admissions to each training each year for the last six years. Training centers and CSBs partner together to ensure that these admissions are time limited and used only as a last resort to community options. In this manner, long-term stays are generally avoided. In 2009, only 8 respite or emergency admissions converted to long-stay regular admissions over 75 days.

Despite efforts between training centers and CSBs to divert admissions, NVTC had the highest respite admission rate per training center for each of the last six years--admitting between 25 and 57 individuals per year for respite care. This rate is significantly higher than Virginia's four other training centers and may indicate a lack of respite care in the Northern Virginia area.

II. Current Practices Diverting Admissions to NVTC and Other Training Centers

Region 2 CSBs and NVTC use a multi-pronged approach to divert admissions to the training center. Generally, there are currently two types of individuals that are at-risk of being admitted to a training center. These are individuals who have extreme behavioral challenges (e.g. aggressiveness toward others, self-injurious behavior, sexual aggression, property destruction) or individuals with extremely medically complex or fragile medical conditions (e.g. require tube feeding and/or have multiple co-morbidities). Region 2 and NVTC have undertaken several efforts to prevent admissions for individuals with both types of conditions. Efforts include:

- Careful assignment of Medicaid ID Waiver slots, when available;
- Use of a Regional Community Support Center (RCSC) based at NVTC;
- Employment of a Clinical Response Team;
- Crisis prevention and stabilization; and,
- Partnerships with DBHDS' Northern Virginia Mental Health Institute (NVMHI) and other acute care hospitals.

Waiver Slots. Each CSB in Region 2 receives allocations of ID waiver slots when they are available. These slots are distributed to individuals who reside in the community and are on the "urgent wait list" for services because they or their family is in crisis and they are in danger of being placed in a hospital, nursing facility, or training center. Carefully assigning these limited slots to individuals helps to prevent admissions to NVTC and other training centers. Additional ID waiver slots would certainly help ensure there are no

[2] 12VAC35-200-10-30. Regulations for Emergency and Respite Admissions to Training Centers.

unnecessary admissions to NVTC or other training centers for both individuals with behavioral challenges and individuals with medically complex conditions. In addition, an improved waiver rate structure would enable more of these individuals to remain in the community as opposed to receiving care in a facility. Specific changes that would address these problems are described in the next section of the report.

Regional Community Support Centers. Each training center receives state general funds annually to provide outpatient medical, dental, behavioral, psychiatric, and other services to individuals with intellectual disabilities who currently reside in the community. Medical, psychiatric, behavioral, allied health (physical therapy, occupational therapy, speech therapy) and dental professionals in the community are generally not available or trained to treat individuals with intellectual disabilities. The Regional Community Support Centers provide specialized services to individuals that might not receive outpatient care otherwise. In FY2010, NVTC provided services to 397 individuals with an estimated cost of $545,000. The tables below show the variety, type, and volume of services provided by NVTC's support center over a five year period.

Table 2: NVTC's RCSC for Five Year Period FY06 to FY10

Total Number of New Clients	403
Total Number of Clients with Active Cases	736
Number of Clients who Received Services	627
Number of Clinical Visits	11,327
Total Hours of Service	11,588
Total Cost of Services	$2,787,184

Table 3: NVTC's RCSC Annual Costs

Cost of Service by Fiscal Year	FY2006	FY2007	FY2008	FY2009	FY2010
	$444,615	$625,868	$586,252	$585,001	$545,448

These outpatient regional support services are critical to preventing illnesses or other problems that can require an admission to a training center, nursing home, or hospital. For example, a behavioral consultation might be provided to an individual who is having trouble adapting to a new group home living situation. This consultation can help staff at the group home learn how to work with the individual and de-escalate behaviors that might otherwise require the individual to move out of the home. In this way, the community placement is preserved and the individual will not require respite or emergency admission to NVTC.

Clinical Response Team. Since 2006, Region 2 has operated a Clinical Response Team which responds in the community within 48 hours to:

- Support individuals with mental illness and intellectual disabilities who are in crisis and at risk for hospitalization;
- Work collaboratively with existing health care providers to help stabilize individuals with mental illness and intellectual disabilities and avert hospitalization; and

- Work with facility staff (NVTC, NVMHI, or an acute care hospital) to facilitate reintegration into the community after a hospital or training center stay.

Alexandria CSB manages the Clinical Response Team on behalf of Region 2. Currently, the Clinical Response Team is only composed of a part-time psychiatrist and a full-time social worker, but it would be better comprised of a behavioral specialist, a nurse, and others as needed through consultation. Fifty-one clients were served in FY10 (Table 4) through crisis prevention, crisis stabilization, hospital diversion, and hospital/facility intervention. Crisis prevention includes outpatient treatment and/or treatment monitoring and/or participation in treatment planning, so as to prevent the occurrence of a clinical crisis while crisis stabilization includes traditional crisis intervention services to prevent escalation of an existing crisis. Hospital diversion is employed in a situation in which acute psychiatric hospitalization is imminent while hospital/facility intervention occurs within the facility to try and limit future re-admission or relapse. The work of this team is critical to preventing admissions to NVTC for individuals with behavioral and mental health challenges.

Table 4: Number of Clients Served, Clinical Response Team

Services - # clients	Alexandria	Arlington	Fairfax	Loudoun	Prince William	Total- 4th Qtr 2010	Total 2010
Crisis Prevention	3	0	2	0	3	8	22
Crisis Stabilization	0	1	0	0	2	3	14
Hospital Diversion	0	0	3	0	1	4	10
Hospital/Facility	0	0	1	0	1	2	5
Consultation	0	0	0	0	0	0	0
Total	**3**	**1**	**6**	**0**	**7**	**17**	**51**

Crisis Prevention and Stabilization Activities. Three crisis stabilization units, located in Arlington, Fairfax, and Manassas, with a total capacity of 26 beds, serve residents of Region 2. The beds are available for persons with an acute psychiatric crisis that could lead to a psychiatric hospitalization. Staff provide crisis stabilization and mobilize community support. Individuals with intellectual disabilities are able to access this resource, but current admission of this population is limited because many require more advanced services such as assistance with activities of daily living, wandering behaviors, and other problems that require more staff assistance than is available in a typical crisis unit serving individuals with a primary diagnosis of mental illness.

All five of Virginia's training centers and the CSBs they serve work closely together to prevent or divert admissions from training centers. All training centers offer Regional Community Support Centers, and the CSBs provide a variety of crisis prevention and stabilization programs to achieve similar goals as Region 2 and NVTC. However, recent data indicates that additional crisis intervention and crisis response resources are needed to divert behavioral crisis admissions to training centers, including NVTC.

In FY2009, each CSB Region identified the following psychiatric beds used by individuals with intellectual disabilities and those additional beds needed to assist other individuals

with intellectual disabilities who are in crisis. CSUs, or crisis stabilization units, also served individuals with intellectual disabilities last year, but more resources are needed (Table 5).

Table 5: FY2009 Psychiatric Bed and Crisis Stabilization Unit Usage and Need

Service	Region I	Region II	Region III	Region IV	Region IV	Totals
Psychiatric Bed Usage[1]	41	25	56	123	53	298
Psychiatric Bed Need[2]	34	25	28	62	41	190
CSU Usage[1]	9	3	7	31	6	56
CSU Need[2]	39	36	37	57	37	206
Total	**123**	**89**	**128**	**273**	**137**	**750**

1/ Utilization in 2009
2/ Need based on 15-day admission over a 365 day period

As mentioned previously, in addition to these documented needs for behavioral crisis intervention, CSBs and training centers continue to struggle to divert admissions for individuals who have complex medical problems or are extremely medically fragile. Additional resources and investments need to be made in ID waiver slots, the ID waiver rate structure, and Regional Community Support Centers to increase diversions for individuals with these conditions.

III. Options to Further Divert Admissions to NVTC and Other Training Centers

The data from Region 2 and across the state clearly indicates that CSBs and training centers have worked closely over the last several years to divert many admissions -- particularly long-term, regular admissions-- to training centers. The commitment of CSBs and training centers to this goal has limited these admissions to an average of 16 per year statewide. These diversions have been achieved through a mix of careful use of waiver slots when they are available, Regional Community Support Centers, and crisis intervention and stabilization programs such as the Clinical Response Team in Region 2.

Region 2 and DBHDS officials agree that more diversions could take place at NVTC and other training centers by building on the existing programs in each region. To further divert admissions, the General Assembly may want to consider one or more of the options below as either a Region 2 pilot or a statewide initiative.

Option 1 – *Provide Additional Support for Regional Community Support Centers on Campus or in the Community.* Currently, Regional Community Support Centers receive the following annual, state general fund appropriation (Table 6). These funding levels could be increased to support additional outpatient medical, psychiatric, behavioral, and dental services for individuals with intellectual disabilities that live in the community.

Table 6: RCSC Appropriations

Training Center	Current Annual State GF Appropriation
NVTC	$ 350,000
CVTC	$ 200,000
SEVTC	$ 200,000
SVTC	$ 200,000
SWVTC	$ 200,000

These valuable services can assist in the prevention of admissions to training centers, including NVTC. It may be feasible to provide some of the funding directly to the CSB Region to cultivate and develop additional community-based medical, psychiatric, behavioral, and psychology expertise among professionals in locations and areas beyond the NVTC campus. For example, Region 2 could use the funding to develop additional capacity for services in outlying regional areas such as Loudoun County. With dollars flowing directly to Region 2, services could be billed to Medicaid directly and/or private insurance, cultivating additional revenue that could be used to expand the availability of services.

Option 2 – *Provide Pilot or Statewide Funding for Regional Crisis Stabilization Programs for Individuals with Intellectual Disabilities.* There is a documented need for additional crisis intervention and crisis stabilization services (see Table 5). In FY2009, CSBs encountered over 750 individuals with an intellectual disability and a co-occurring mental health or behavioral problem that required crisis prevention or intervention to ensure the individual's, their caretakers', or the public's safety. Psychiatric hospitals and mental health crisis stabilization programs were only adequately staffed to serve 50% of these individuals. Each CSB region has identified a significant need for additional crisis stabilization beds and crisis intervention programs to reach individuals with a primary intellectual disability diagnosis to either prevent crisis or prevent escalation to full-term admission to a training center, psychiatric hospital, and/or incarceration. DBHDS and CSBs estimate the establishment of one "Crisis Intervention Team" in each region and the creation of 4-6 crisis stabilization beds specifically for the ID population in each region would significantly reduce emergency placements at training centers, unnecessary psychiatric hospitalizations, incarcerations, or removal from an individual's home.

The Crisis Intervention Teams would assist providers and families with preventing crises before they develop and/or assisting when an individual's behavior has escalated to the level that an out-of-home placement may be needed. The teams would be composed of up to 1 FTE psychiatrist, 1-2 FTE regional coordinators, 2 clinicians (e.g. nurses or psychologists), and 4-6 staff with specific training in behavioral intervention. With these resources the teams could provide emergency, 24 hour, assistance to families and community providers serving an individual in crisis or who is nearing crisis. These teams would reduce the number of out of home placements and psychiatric hospitalizations and maintain individuals in their homes. It is estimated that these teams would require $1,683,560 annually to serve all five regions.

Each region would also establish or build upon existing crisis stabilization units or services to add capacity for individuals with intellectual disabilities. These additional beds would require additional staff specifically trained to treat and understand the complexities of individuals with an intellectual disability and a co-occurring mental illness and/or behavioral problem. Each region has estimated the addition of 4-6 beds which would provide approximately 24 admissions per bed per year. The annual estimated cost to operate these beds is $1,207,057. Each region would also require one-time start up costs to purchase equipment and/or bed space. Initial start-up is estimated to be $722,653 in year one of the proposal. Total first year costs to start an ID crisis stabilization program in each region would be $3,613,270 and $2,890,617 annually thereafter. Table 7 shows the estimated costs by CSB Region.

Table 7: Estimated Costs Per Region for Crisis Stabilization and Intervention Teams

	CSU	CIT	Start-Up	Total Year One Cost	Total Ongoing Annual Cost
HPR I	$510,689	$320,780	$207,867	$1,039,336	$831,469
HPR II	$135,140	$443,600	$144,685	$723,425	$578,740
HPR III	$222,239	$331,460	$138,424	$692,123	$553,699
HPR IV	$228,800	$146,100	$93,725	$468,625	$374,900
HPR V	$110,189	$441,620	137,952	$689,761	$551,809
State Total	**$1,207,057**	**$1,683,560**	**$722,653**	**$3,613,270**	**$2,890,617**

Option 3 – *Expand the number of ID waiver slots and examine methods to improve the overall rate structure to meet the needs of the most medically complex and behaviorally complex individuals.* The growth of the ID waiver program since the early 1990s has enabled more and more individuals with intellectual disabilities to remain in the community or in their family homes. The expansion of the program has also permitted many individuals living in training centers to return to the community. Lastly, careful use of slots by CSBs and training centers has diverted many admissions from training centers. Region 2 and DBHDS support approval of additional ID waiver slots to continue expansion of the community system and ensure slots are available for individuals in need so they do not have to be admitted to a training center for care.

The General Assembly has a long history of approving funding for ID waiver slots. Most recently and in a significant budget crisis, 250 waiver slots were approved in 2010. It is estimated that 400 slots are needed over the next 8 years to alleviate the ID waiver waiting list and ensure everyone who qualifies for a waiver needs are met. Additional slots would be required to serve individuals transitioning out of training centers.

Creating enough waiver slots for those in need is one of two actions necessary to ensure the most medically fragile and behaviorally complex individuals can continue to reside in the community and not be admitted to training centers. An improved waiver rate and services structure also will assist those with medical and behavioral challenges. Currently, the average annual cost of ICF care is $181,000 per year. The waiver program only provides resources in the amount of $143,000 per year to the same individual with the same level of supports in the community. This disparity makes it difficult for those with

complex medical or behavioral conditions to receive sufficient care and services under the ID waiver program. The ability of CSBs to divert an admission to training center can be limited because of insufficient resources to purchase care in the community.

To improve the overall waiver structure, DBHDS—in concert with stakeholders—must examine what service payment rate increases are required to provide sufficient resources to individuals with complex conditions under the waiver. This effort should be undertaken on a statewide basis and not simply for individuals in the Northern Virginia area. DBHDS and Region 2 support a study of the current ID waiver program to map out the appropriate waiver rates and structure for the waiver program.

The study would require the authors to prioritize how the waiver should be modified to address additional medical and behavioral needs and reflect best-practices in other state waiver programs. For example, general supervision is not currently available as a waiver service, making it nearly impossible for someone who requires 24 hour care to obtain sufficient staffing to live in the community with a waiver. Another example is the limited payment rates for skilled nursing. The rate is too low to attract a significant number of providers to provide the service. Last, those requiring behavioral consultation, have difficulty accessing services because payment only provides for the actual face-to-face consultation with the client and not the development of a behavior support plan or training of providers.

Option 4 – *Expand the number of out of home respite providers available in Region 2.* Currently, NVTC provides a significantly higher rate of respite services to individuals living in Region 2 than other training centers provide in their respective regions. These admissions can be difficult to plan for and significantly strain staffing and resources at NVTC. The respite admissions can last for up to 21 days and they provide 24 hour care to individuals that reside in the community. The ID waiver provides up to 720 hours of respite care per year in an individual's home, but it does not support more involved respite care outside of a person's home. The limitations on the waiver's respite service limits the access individuals have for care and may create situations where individuals have no choice but to be admitted to NVTC for respite care.

Expanding and developing out of home respite placements in Region 2 would divert many admissions per year to NVTC. Development of respite services would either require capital funding, start up costs, and operational costs or a partnership with a local private provider to develop the service.

IV. Summary: Options to Establish a Northern Virginia Pilot Project

It is clear that NVTC and Region 2, as well as the other training centers and CSB regions in Virginia, have made significant strides in the last decade to reduce the number of regular, long-term admissions to training centers. These same partnerships with the support of the General Assembly have also ensured the growth in the number of waiver slots to permit people to remain in the community, the construction of Regional Community Support Centers to provide services that divert admissions to public and

private institutions and the development of crisis prevention and crisis stabilization services to prevent admissions to NVTC and other training centers.

A pilot project that would harness the success of the current programs in place in Northern Virginia and/or across Virginia must address the following areas and would likely require additional funding or partnerships with private providers:

- Provide additional support for Regional Community Support Centers to expand the number of medical, behavioral, psychology, and psychiatric expertise available to individuals and families that reside in communities. Region 2 recommends an increase in state general fund from $350,000 annually to $600,000 annually for NVTC and the establishment of a Support Center off-site from NVTC's campus to be managed or contracted by the Region 2 group of CSBs. Development of a Support Center off-site from NVTC's campus would either require capital funding, start up costs, and operational costs or a partnership with a local private provider to develop the service.

- Provide funding to increase access to crisis prevention, intervention, and stabilization services for individuals with ID who have co-occurring mental illnesses or behavioral problems. Table 7 outlines the costs associated with funding either a Northern Virginia pilot or a statewide program.

- Expand the number of waiver slots to permit people to remain in the community and divert admissions to training centers. More importantly, undertake a year long study to determine methods to improve Virginia's overall ID waiver structure and rates. The current ID waiver does not provide sufficient funding for the most medically and behaviorally complex individuals to obtain needed care in the community. Without significant changes to waiver program's services, payment rates, and structure, little more can be done to divert admissions to training centers for the most medically fragile and behaviorally challenging individuals.

- Through private provider partnerships or some other vehicle, develop additional out-of-home respite services for individual residing in Northern Virginia. Currently, this service is not widely available in Northern Virginia and drives a large percentage of respite admissions to NVTC. Development of this service could significantly reduce the number of respite admissions from NVTC. A pilot in the Northern Virginia area with a private provider may provide data about demand and supply for this valuable service that can be duplicated in other regions of the Commonwealth.