DBHDS

Virginia Department of
Behavioral Health and
Developmental Services

Item 319.A.2. - Bed Capacity Study of Northern Virginia Mental Health Institute

to the Chairs of the
House Appropriations and Senate Finance Committees

November 20, 2012

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

COMMONWEALTH of VIRGINIA

JAMES W. STEWART, III
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 20, 2012

The Honorable Walter A. Stosch
Chair, Senate Finance Committee
General Assembly Building, Suite 626
Richmond, VA 23219

Dear Senator Stosch:

Pursuant to Item 319.A.2. of the 2012 *Appropriation Act*, enclosed is the required study report on a long-term funding plan for inpatient bed capacity in the catchment area served by Northern Virginia Mental Health Institute (NVMHI) outlining specific strategies and plans to meet the psychiatric inpatient and inpatient diversion needs of individuals with serious and persistent mental illness who are served by the publicly funded mental health system, developed via a workgroup of stakeholders. The assessment of the cost and feasibility of creating an alternative to re-opening beds at NVMHI is also required.

Thank you for the opportunity to present this information. Please feel free to contact me if you have questions about the report. I can be reached at (804) 786-3921 or via email (jim.stewart@dbhds.virginia.gov).

Sincerely,

James W. Stewart, III

Cc: The Honorable Emmett W. Hanger, Jr.
The Honorable William A. Hazel, Jr., M.D.
Olivia J. Garland, Ph.D.
John Pezzoli

COMMONWEALTH of VIRGINIA

JAMES W. STEWART, III
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 20, 2012

The Honorable Lacey E. Putney
Chair, House Appropriations Committee
General Assembly Building, Room 947
Richmond, VA 23218

Dear Delegate Putney:

Pursuant to Item 319.A.2. of the 2012 *Appropriation Act*, enclosed is the required study report on a long-term funding plan for inpatient bed capacity in the catchment area served by Northern Virginia Mental Health Institute (NVMHI) outlining specific strategies and plans to meet the psychiatric inpatient and inpatient diversion needs of individuals with serious and persistent mental illness who are served by the publicly funded mental health system, developed via a workgroup of stakeholders. The assessment of the cost and feasibility of creating an alternative to re-opening beds at NVMHI is also required.

Thank you for the opportunity to present this information. Please feel free to contact me if you have questions about the report. I can be reached at (804) 786-3921 or via email (jim.stewart@dbhds.virginia.gov).

Sincerely,

James W. Stewart, III

Cc: The Honorable Riley E. Ingram
The Honorable William A. Hazel, Jr., M.D.
Susan Massart
Olivia J. Garland, Ph.D.
John Pezzoli

COMMONWEALTH of VIRGINIA

JAMES W. STEWART, III
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

November 20, 2012

The Honorable Linda T. Puller
Chair, Joint Commission on Health Care
900 E. Main Street
1st Floor West
Richmond, VA 23219

Dear Senator Puller:

Pursuant to Item 319.A.2. of the 2012 *Appropriation Act*, enclosed is the required study report on a long-term funding plan for inpatient bed capacity in the catchment area served by Northern Virginia Mental Health Institute (NVMHI) outlining specific strategies and plans to meet the psychiatric inpatient and inpatient diversion needs of individuals with serious and persistent mental illness who are served by the publicly funded mental health system, developed via a workgroup of stakeholders. The assessment of the cost and feasibility of creating an alternative to re-opening beds at NVMHI is also required.

Thank you for the opportunity to present this information. Please feel free to contact me if you have questions about the report. I can be reached at (804) 786-3921 or via email (jim.stewart@dbhds.virginia.gov).

Sincerely,

James W. Stewart, III

Cc: The Honorable William A. Hazel, Jr., M.D.
Olivia J. Garland, Ph.D.
John Pezzoli
Kim Snead

Item 319.A.2. - Bed Capacity Study of
Northern Virginia Mental Health Institute
November 20, 2012

TABLE OF CONTENTS

Item 319.A.2. - Bed Capacity Study of
Northern Virginia Mental Health Institute
November 20, 2012

EXECUTIVE SUMMARY

The 2012 General Assembly, through Item 319.A.2. of the 2012 *Appropriation Act*, requested the Department of Behavioral Health and Developmental Services (DBHDS) conduct a study regarding Northern Virginia Mental Health Institute, as follows:

"The Commissioner of the Department of Behavioral Health and Developmental Services shall convene a workgroup to develop a long-term funding plan for inpatient bed capacity in the catchment area served by NVMHI. The report shall outline specific strategies and plans to meet the psychiatric inpatient and inpatient diversion needs of individuals with serious and persistent mental illness who are served by the publicly funded mental health system. The Commissioner shall also assess the cost and feasibility of creating an alternative to re-opening beds at NVMHI. The Commissioner shall report his findings no later than October 1, 2012 to the Chairmen of the Senate Finance and House Appropriations Committees as well as the Joint Commission on Health Care."

The language was accompanied by $600,000 in additional state general funds in FY13 for the operation of the Northern Virginia Mental Health Institute (NVMHI).

DBHDS formed a stakeholder workgroup made up of NVMHI and DBHDS staff and representatives from all area CSBs and private hospitals to conduct the review. The review led to the following main findings:

- The Northern Virginia area has fewer psychiatric hospital beds per capita (both public and private) than any region of Virginia.
- The CSBs in the Northern Virginia region make maximum feasible use of both public and private hospital beds in the area, yet frequently must seek care for persons in hospitals far away from their homes.
- The need for maintenance of bed capacity at NVMHI has been so great that CSBs in the area have used funds intended for community services to keep 123 NVMHI beds open over the past three years. This means of supporting state hospital beds is not sustainable.
- Many practical alternatives to divert persons from inpatient care or to maintain them in the community with lessened need for inpatient care were researched; however, the cost and time required to develop and implement them make it necessary to restore bed capacity at NVMHI and continue full capacity operation for at least the next two years.

It is recommended that:

1. NVMHI be restored to its original (pre-2010) operational capacity of 129 beds, requiring an annual increase in allocated state general funds of $1,400,000 per year, beginning on July 1, 2013.
2. The Region II CSBs redirect 100% of the state general funds that are granted to individual CSBs and the Region for local inpatient purchase of service (LIPOS) and other inpatient diversion services to the purposes for which they were originally granted in order to decrease pressure for use of NVMHI.

3. Expanded program capacity designed to reduce the reliance on inpatient hospitalization be implemented in Region II on a continuing basis as soon as funding can be made available for this purpose.

Item 319.A.2. - Bed Capacity Study of Northern Virginia Mental Health Institute
November 20, 2012

I. PURPOSE

The 2012 General Assembly, through Item 319.A.2. of the 2012 *Appropriation Act*, requested the Department of Behavioral Health and Developmental Services (DBHDS) conduct a study regarding Northern Virginia Mental Health Institute (NVMHI), as follows:

"The Commissioner of the Department of Behavioral Health and Developmental Services shall convene a workgroup to develop a long-term funding plan for inpatient bed capacity in the catchment area served by NVMHI. The report shall outline specific strategies and plans to meet the psychiatric inpatient and inpatient diversion needs of individuals with serious and persistent mental illness who are served by the publicly funded mental health system. The Commissioner shall also assess the cost and feasibility of creating an alternative to re-opening beds at NVMHI. The Commissioner shall report his findings no later than October 1, 2012 to the Chairmen of the Senate Finance and House Appropriations Committees as well as the Joint Commission on Health Care."

The language was accompanied by $600,000 in additional state general funds in FY13 for the operation of the Northern Virginia Mental Health Institute.

BACKGROUND

The FY2010-11 *Appropriation Act* mandated cuts in state general funds (SGF) totaling 11% for DBHDS. In an effort to minimize cuts in direct services, DBHDS allocated these reductions disproportionately across its operations. For instance, in 2009 and 2010, Central Office operations absorbed a 30% reduction, while a reduction of 2.7% was applied to the SGF allocation to the facilities. Since the level of SGF constitutes a different proportion of each facility's budget, each facility was tasked with developing its own cost savings plan to implement the reduction and further, to make cuts in a manner which had the least amount of negative impact on patient care. NVMHI is almost wholly supported by SGF and the reduction of state general funds amounted to $1,801,172 per year, and equaled 7% of the facility's total budget for FY10. An additional reduction of $491,721 announced in 2010 brought the total reduction for NVMHI to $2,292,893 or 8% total over both years.

In addition to cuts in administrative functions, NVMHI decided that it must also close an admissions unit, cutting clinical and direct support staffing and reducing operating bed capacity from 129 to 110 beds. (See the Appendix A-1 for a detailed analysis of the budget adjustments for the period.)

In May 2010, in response to concerns from local providers and stakeholders about the impact of these planned reductions in NVMHI's inpatient bed capacity, the commissioner proactively assembled a team of DBHDS and community services board (CSB) staff to review the NVMHI budget and bed reduction decision. The conclusion of this review was that, while some improved efficiencies in operations and staffing could be found for NVMHI, the beds that had been planned for closure needed to be restored to the greatest extent possible and additional funding was necessary to achieve this goal.

The CSBs in the Region II (Alexandria, Arlington, Fairfax-Falls Church, Loudoun County, and Prince William) began to utilize state general funds that had been granted for local inpatient purchase of services (LIPOS) purposes to maintain bed capacity at NVMHI after it was determined that adequate acute care beds could not be obtained from private hospitals in the region to make up for the loss of NVMHI's beds.. As a result, the full planned reduction from 129 to 110 beds was never implemented. The region continues to support the operation of 13 acute admissions beds at NVMHI, thus holding the bed capacity at 123. Also, when possible during this period, DBHDS contributed one-time funds that became available or covered certain costs directly for NVMHI. (Appendix A-1 itemizes all of these budget adjustments).

However, neither the CSBs in the region nor DBHDS are able to maintain this level of support for NVMHI on an ongoing basis. DBHDS has identified the reinstatement of these beds as a high priority in its planning. Access to inpatient care is a foundation of the behavioral health services system, especially in the absence of services to divert individuals with mental illness from the criminal justice system or crisis stabilization services. This was noted in DBHDS' strategic planning initiative *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*, as well as historical problems of timely access and needs of special populations (medical needs, multiple diagnoses, geriatric, etc). The Office of the Inspector General (OIG) also has documented in two reports, *A 2011 Study Examining Unexecuted Temporary Orders (TDOs) in the Commonwealth February 2012) and* the *Office of the Inspector General Semi-Annual Report for April 1, 2011 – September 30, 1011,* the statewide problem of delays and difficulties in finding timely access to acute care including in the Region II (Northern Virginia) area. In April 2012, the regional CSBs drafted a paper documenting their role in this process and requesting DBHDS to develop concrete plans for the future of acute care in Northern Virginia (Appendix A-2). The General Assembly addressed the issue by providing $600,000 for FY13 only and ordering this study.

II. STUDY STRUCTURE

DBHDS called a meeting with the Region II CSBs in late April 2012 to receive input and invite participation for the study. DBHDS formed a stakeholder workgroup to collect data and provide information. A total of 39 persons were ultimately involved in the project. Stakeholders included CSB staff from all Region II CSBs, representatives of all local hospitals, staff from six DBHDS hospitals, including NVMHI, and representatives from DBHDS' central office. A complete committee roster is included in Appendix A-3.)

The committee met at NVMHI twice in both June and July, or a total of four times. Three subcommittees were formed and met periodically, producing reports for the committee's consideration:

- Crisis Response and Diversion Subcommittee: addressed services needed to divert admissions from acute care.
- Discharge and Community Support Subcommittee: examined services needed to discharge and support persons in the community (thus preventing crises and providing alternatives to hospital care)
- Facility Budget and Operations Review Subcommittee: reviewed the facility's staffing patterns, budgets, operating costs and procedures, security, clinical services, admission and discharge criteria, etc.

The committee conducted the following analyses:

- Reviewed admissions, discharges and census at NVMHI for 2010-2012;
- Collected data regarding the historical needs for inpatient psychiatric beds at NVMHI and at community hospitals;
- Interviewed private hospitals to learn of their capacity, average census, reasons for not being able to serve certain patients, views of their roles and that of NVMHI, etc.;
- Assessed the relative demand and use of both state and private hospitals by CSBs for the region and statewide;
- Completed a comprehensive assessment of private and public psychiatric bed capacity availability per capita for all regions of Virginia over the past ten years;
- Studied demographics, clinical status, processing, and length of stay (LOS) of forensic patients.

After reviewing the information listed above, the committee assessed needs, projected costs, and prioritized services in the following areas that would provide an alternative to the operation of beds at NVMHI:

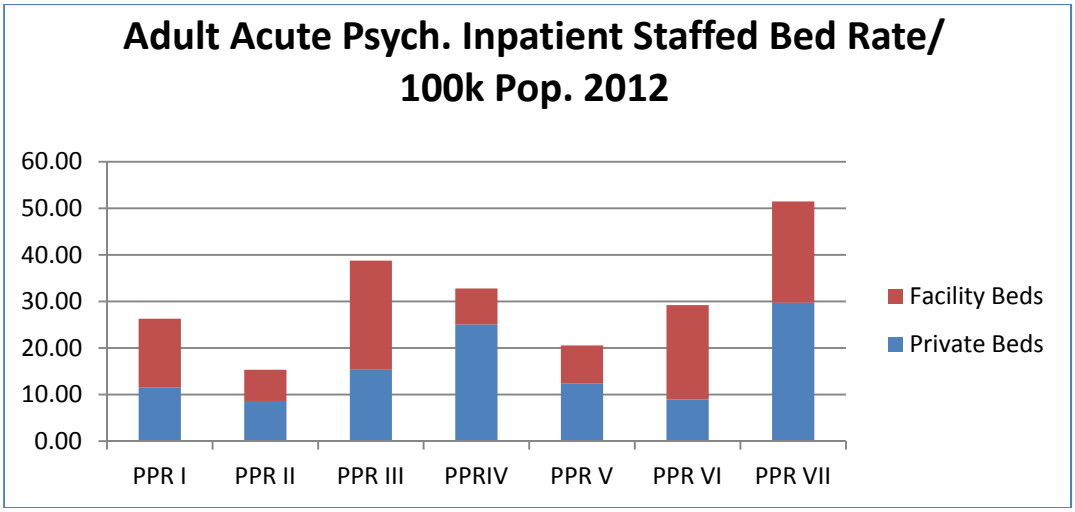
- Services to reduce admissions by preventing or reducing the incidence and severity of psychiatric crises, including community-based crisis intervention and crisis stabilization services.
- Services that would allow persons in long term care at NVMHI (including forensic patients) to be discharged and supported in permanent, safe housing that may help prevent future needs for hospital care.

Detailed description and costs for the above services are found in this report under the section titled 'Finding from Review of Alternatives to re-opening the 129 bed capacity of NVMHI' beginning on page 18.

III. FINDINGS: REVIEW OF NVMHI PROGRAMS, REGIONAL SERVICES AND NEEDS

1. Northern Virginia is under-resourced in terms of psychiatric beds per capita when compared to all other regions of Virginia.

- DBHDS divides the state into seven Partnership Planning Regions (PPRs) centered on the DBHDS adult mental health hospitals' catchment areas. Each of these seven PPRs has more psychiatric hospital beds per capita, *both private and public,* than does Region II (the Northern Virginia area) although PPR II has the highest population of any of the seven regions. The following table and related points illustrate these comparisons.



- Northern Virginia has the lowest number of state hospital beds per capita.
- PPR II has the fewest per capita private hospital beds thus causing the region to rely even more heavily on state hospital beds. PPR II has the lowest number of crisis stabilization (alternatives to hospitalization) beds per capita of all but two regions.
- The limited number of beds actually accessible for public use has led to a chronic access problem for Region II citizens.
- Private hospitals statewide have lost beds, mirroring a national trend From a total of 1844 private psychiatric beds in all of Virginia in 2001 the total has been reduced to 1561 in 2012, a 15% loss. Also of note is the region's diminished number of private hospital beds compared to other regions: PPR II has lost 44 beds in the private sector.
- Public psychiatric hospital bed capacity in Virginia has remained relatively constant in recent years, except for the proposed but never fully implemented reduction of NVMHI beds.
- A complete analysis of all aspects of bed allocation in Virginia is available in Appendix A-4. The detailed analysis is a joint project of the Virginia Hospital and Healthcare Association (VHHA) and DBHDS.

2. *Needs assessments consistently show the need for more beds in Northern Virginia, now and in the future.*

Numerous studies and assessments have documented the need for inpatient psychiatric beds in Northern Virginia, as described below:

- A 2009 study by the Virginia Department of Health showed a need for an additional 83 psychiatric beds for the Northern Virginia area. Region II CSBs have supported the maintenance of full capacity at NVMHI, and the members of the stakeholder group contributing to this study strongly endorse the retention of 129 beds at NVMHI. Four recent OIG reports document the need for improved crisis response services in most of Virginia, but including acute inpatient access in Region II:
  - May 17, 2012: *Office of the Inspector General Semi-Annual Report for October 1, 2011 – March 31, 2012;*

- June 14, 2012: *Office of the Inspector General Update of the Biannual Report for the Joint Commission on Health Care; and*
- November 2009 Report #183-09 *Review of the Residential Crisis Stabilization Units Operated by Community Service Boards – October – November 2009*
- August 2005 Report #123- 05 *Review of Community Services Board - Emergency Services Programs*

- DBHDS, in its Creating Opportunities strategic plan, has placed a high priority on improving crisis response services, including timely access to inpatient psychiatric care when needed and to alternatives to hospitalization when inpatient is not needed.
- Northern Virginia is the fastest growing area of Virginia and one of the fastest growing areas in the country. The Weldon-Cooper Institute, the Northern Virginia Regional Commission, the Virginia Employment Commission, and the Metropolitan Washington Council of Governments all forecast increased population growth in Northern Virginia over the next 20 years, particularly in Prince William and Loudoun counties. Although growth is not expected to be as high as the last decade (23%), the current need for access to inpatient care is acute, and the situation is will become worse in the future.

3. ***Current utilization of both public and private inpatient psychiatric hospital beds is high and often the regional supply cannot meet the needs of persons needing acute inpatient admission. Often, persons needing inpatient care must wait in emergency rooms for extended periods before an accepting facility can be found and its location is occasionally as much as 100 miles from Northern Virginia.***

The regional CSB structure administers an aggressively managed bed utilization process. Generally, when a need exists for inpatient psychiatric care, the first option is to seek care at local partnering private hospitals. Persons qualifying for Temporary Detention Orders (TDOs) must be accepted by a willing facility to execute the TDO. Payment for indigent persons is assured with the TDO, as funds are provided through a fund administered by the Supreme Court of Virginia (SCV). Additionally, the region administers a pool of funds to purchase beds from local private hospitals when the TDO expires and a commitment order is issued. As explained previously, these LIPOS funds are mostly state general funds allocated to the regions since FY2000 to promote use of local private hospitals for acute admissions and to divert such admissions from state hospitals. In FY 2012, CSBs reported spending $10,311,131 on the statewide purchase of MH local inpatient services, funded by a variety of state and local funds, for 2,293 individuals.

Lack of payment is rarely, if ever, the barrier to bed access in Northern Virginia (or in any other region, though some regions in some years run short of LIPOS funds.) In many cases, private partner hospitals take these patients as unfunded and work with the region to support the partnership with funding when possible.

In FY12, a total of 491 admissions of persons to private hospitals were paid for with $1,779,137 of LIPOS funds by Region II. The average length of stay for LIPOS-supported patients in private community hospitals was 5.4 days. Approximately 30% of these patients are transferred to NVMHI when discharged from the community hospital. The remaining 70% are stabilized, discharged, and referred to a less acute form of care.

Persons in crisis and their families need to be treated in their home communities for a variety of reasons, but most obviously for completion of critical discharge planning functions that reduce the likelihood of re-admissions.

Related Points:

- Bed utilization at NVMHI has remained consistently high for the last several years, ranging from an average of 96% in FY 11 to 92% last year.1 A more complete analysis of occupancy rates can be found in Appendix A-5.

Period	Admissions	Discharges	Occupancy Rate	Bed Capacity
FY06	602	604	96%	129
FY07	775	782	97%	129
FY08	806	807	96%	129
FY09	976	978	93%	129
FY10	985	998	95%	129
FY11	873	878	96%	123
FY12	763	767	92%	123

- Occupancy rates for private psychiatric hospitals are not published and were not made available for all hospitals participating in the study. However, all information received for this study suggests that the units are generally full, or restrictions on the hospitals' ability and willingness to accept some patients render them effectively full. These limitations were discussed in depth by the committee and are detailed below.
- It is commonplace that CSB emergency services pre-admission screeners cannot find private hospitals that will accept certain persons at certain times.
- As noted above, the problems of access to appropriate emergency psychiatric care are well documented by DBHDS and the OIG.
- CSB pre-admission screeners, not finding access to a bed in Northern Virginia, report that on occasion they have called as many as 35 hospitals across the state to find an accepting facility.
- In FY12, 191 persons had to be referred to hospitals outside the region. A study determined that, of the 223 persons who needed to be sent to hospitals outside HPRII in FY11, law enforcement traveled a total of 48,572 miles to transport these persons to the designated hospitals.
- A good partnership among the private and public sectors exists in Northern Virginia, with little to no "finger pointing" and a shared sense of mutual dependence and cooperation. Many participants said the stakeholder meetings held for this study increased the cooperation. (a complete hospital-by-hospital version of this report is available as Appendix A-6). VHHA surveyed the private hospitals located in the Region II area and those as far away as Fredericksburg and Richmond which receive patients from Northern Virginia. While occupancy rates are respected as proprietary information by the private providers, many indications of access problems were identified. The private hospitals shared the following information openly with the stakeholder panel.

[1] The slight decline in FY2012 is due to reconfiguration of units for greater staffing efficiency and consequent lowered flexibility of male/female rooms and the need to hold open beds due to lack of gender match. It is planned to reverse this staffing decision if funding allows.

- Operating at full capacity is the primary reason given for not accepting patients. Many of the private hospital units are small, with limited flexibility in some cases, affected by gender or other room restrictions.
- Acute illnesses, questions of medical assessment, detoxification risks, and other medical needs prevent some admissions. Most private psychiatric hospitals do not have medical treatment capabilities or staffing for complex medical needs.
- Some hospital beds are specialized, i.e., dedicated for a specific purpose or population and not open to all persons. In Northern Virginia some of the beds are reserved for eating disorders, children or adolescents, or other specific conditions.
- One large Northern Virginia hospital is limited by local government zoning requirements to not accept involuntary patients, which are by far the most common need for the CSBs in the region.
- Many local private hospitals state they cannot serve persons in forensic status, persons with intellectual disabilities, persons in detoxification from alcohol or other drugs, primary substance abuse diagnoses, persons with traumatic brain injuries, or, most commonly, persons with a history of violence or disruptiveness to patients or staff.
- In many cases, some private hospitals decline admissions due to what is termed "acuity mix." This refers to the difficulty of accepting, for example, an agitated, disruptive and difficult to manage person on the unit with older, depressed, vulnerable persons. The business model of these hospitals can be negatively affected by such patients and as private businesses, these hospitals are under no requirement to accept patients they cannot or prefer not to serve.
  These characteristics describe many public sector patients, and these "rule outs" are what CSB emergency services staff face when they look for beds, thus increasing the pressure on NVMHI to accept persons for acute care, in spite of its limited capacity to do so.

4. Limited bed capacity and admission policies of the private hospitals put pressure on NVMHI to accept more acute inpatient admissions.

- For efficient management of public funds, the region's CSBs try to refer patients with insurance coverage to private providers. Persons with insurance are referred to psychiatric beds in the private sector because of the available insurance reimbursements. NVMHI admits persons with insurance when the private sector does not have available beds, either due to full occupancy or the clinical complexities of the person. Despite rigorous efforts to admit insured persons elsewhere, 22% of NVMHI admissions in FY12 had insurance.
- Persons under TDO are first referred to psychiatric beds in the private sector, where they are able to be served due to the previously mentioned Supreme Court fund. NVMHI admits persons on TDO status when the private sector does not have available beds. Despite rigorous efforts to keep NVMHI as the TDO placement of last resort, 23% of NVMHI admissions in FY12 were TDOs (FY11=33%).
- Acute admissions generally have a lower length of stay than most other state hospital patients, which includes large numbers of persons with conditions or legal statuses that

require longer stays. None of Virginia's state hospitals is purely one type or another, as all have persons with severe and complex mental illnesses, who require longer term care and 'not guilty by reason of insanity' (NGRI) patients, whose stays are generally longer. Nevertheless, the mean length of stay for NVMHI shows the degree to which it serves as an acute hospital for Northern Virginia. NVMHI must accept a high proportion of acute patients (due to lack of available acute beds in community coupled with many patients meeting the "rule out" criteria for private hospital admission) and functionally must act as an acute stabilization hospital, while simultaneously acting as a facility to care for patients in need of longer term care and also functioning as a facility to provide long term care for NGRI consumers. The chart below clearly shows that NVMHI must function as an acute care program to a larger degree than other state operated hospitals (as evidenced by the significantly lower LOS).

COMPARISON OF MEAN AND MEDIAN LENGTH OF STAY (LOS) FOR STATE HOSPITALS (TOTAL DAYS)

HOSPITAL	MEAN LOS	MEDIAN LOS
Catawba Hospital*	199	43
Central State Hospital (CSH)	339	66
Commonwealth Center for Children and Adolescents (CCCA)**	17	11
Eastern State Hospital (ESH)*	1451	296
NVMHI	**86**	**20**
Piedmont Geriatric Hospital (PGH)*	872	438
Southern Virginia Mental Health Institute (SVMHI)	208	35
Southwestern Virginia Mental Health Institute (SWVMHI)*	221	47
Western State Hospital (WSH)	289	62

*partial or full occupancy by geriatric patients – who have generally longer LOS
**short term children's psychiatric hospital

5. ***Forensic services account for a large portion of NVMHI bed use but are comparable to other DBHDS facilities. NVMHI's forensic services are efficiently managed and consistent with the mission of the department. However, jail inmates from HPR II who need emergency treatment or restoration to competency to stand trial are served at WSH. No other DBHDS hospital requires such a "back-up" arrangement with another state hospital to meet the needs of its region.***

The following data are detailed in Appendix A-7.

FORENSIC SERVICES

OVERVIEW OF FORENSICS

- HPR II's population equals approximately 28% of Virginia's overall population.
  - Forensic Admissions from HPR II accounted for 20% of all forensic admissions to state hospitals.
  - Inpatient Restoration of Competency to Stand Trial and Sanity evaluations from HPR II accounted for 26% of all such evaluations in state hospitals.

- Orders for Inpatient Competency Restoration from HPR II accounted for 21% of all such orders in state hospitals
- Orders for Emergency Treatment (ETO)/ Jail Transfers from HPR II accounted for 19% of all such orders in Virginia.

- Competency to stand trial and other forensic jail transfers
  - A snapshot taken on July 5, 2012 found 30 forensic patients from HPR II at WSH. This is about the average at any given time.
  - Rates for use of these services are slightly above other regions.
  - Demand for forensic services for residents of HPR II is expected to remain stable, with normal growth, suggesting back-up capacity at WSH will be needed into the future.
- Not Guilty by Reason of Insanity (NGRI) Issues
  - NGRI acquittees are persons who are court ordered for treatment in DBHDS facilities. They go through an exacting series of graduated assessments and increases in privilege until DBHDS deems them qualified for conditional release to the community. To be conditionally released, the committing local court must also agree and approve the conditional release plan.
  - NVMHI's share of NGRI acquittees is only slightly above the state average.
  - NVMHI's processing of NGRI acquittees yields the shortest lengths of stay of any state hospital. Its average LOS for NGRIs is about 3.6 years, which is 45% below the state average of 6.5 years.

FUTURE NEEDS FOR FORENSIC SERVICES

- Based on NGRI growth rate at NVMHI over the last 9 years, it is estimated that NGRIs will take up at most 2 more beds every 3 years (growth rate over last 9 years = .33/ Growth rate over last 3 years = .66/year).
- There have been periods of volatile change in population (both increases and decreases). Therefore, there may be short periods of time when the NGRI population either grows larger than expected or shrinks more than expected, but over time the growth should be relatively slow (all things being the same – e.g. not significant increase in NGRI acquittal rate, no sudden lack of services in community to support Conditional Release, etc). Highest census over the last 3 years has been 35, but that only lasted one month. Lowest census has been 25.
- To keep pace, HPR II will need to Conditionally Release/ Resume Conditional Release for 10 individuals per year (on average – not counting those Conditionally Released straight out of Temporary Custody)
- At this point in time, it does not appear that NGRIs will encumber a larger proportion of available beds at NVMHI. They currently occupy 26% of NVMHI beds and, absent any loss of beds: that proportion will not increase to 30% until 2021.
- As long as NVMHI continues to have WSH as a back-up for all other forensic admissions, the NGRIs should not consume a larger proportion of beds than are consumed at other hospitals by forensic consumers (statewide average currently is 36%).

6. ***As at all DBHDS facilities, there are patients at NVMHI who are clinically ready for discharge but cannot be discharged from the hospital due to inadequate community services, especially housing and other support services, that would allow them to***

return to their communities. The number of ready for discharge patients at NVMHI is higher than at most other DBHBS facilities.

- Barriers to timely discharge of patients from state hospitals have been documented by the DBHDS *Creating Opportunities* strategic plan and a recent OIG report (OIG Report # 207-12). On average, approximately 150-160 persons are on the "Extraordinary Barriers to Discharge List (EBL)" statewide.
- In September, 2012, when data were collected for this study, there were 25 persons at NVMHI on the EBL. This is approximately 20% of the population of NVMHI, which is higher than the statewide average. (see chart below)
- It appears that NVMHI is experiencing greater difficulty than in other regions in placing its patients who are on the EBL. The chart below shows the average length of stay for persons on the EBL at the various hospitals. These data support the need for discharge assistance planning (DAP) funding and community alternatives in all of Virginia, but perhaps especially in Northern Virginia.
- The needs of the persons on the EBL at NVMHI are typical of those at all other hospitals. These persons need housing, often with supervision. They have medical or behavioral challenges that make placement difficult and expensive, or may need specialized nursing home care, or are NGRI and not yet ready for conditional release (or, if they are, a placement cannot be found).
- If any of these persons with very long lengths of stay can be discharged, the resulting open bed could be available for multiple shorter term admissions, thereby increasing access to inpatient care in the region. For example, if a person who has been in the facility for 365 days is discharged, based on average length of stay at 20 days, 18 admissions could be served in that bed in a year. This is why Discharge Assistance Program funding (DAP) for discharge plans is DBHDS's highest behavioral health priority for new funds.

INDIVIDUALS WITH EXTRAORDINARY BARRIERS TO DISCHARGE SEPTEMBER 12, 2012

HOSPITAL	OPERATIONAL CAPACITY	# ON EBL	PERCENT OF OPERATIONAL CAPACTIY	AVERAGE EBL DAYS
CATAWBA	120	10	8%	**188**
CENTRAL STATE	277	12	4%	**178**
EASTERN STATE	300	52	17%	**307**
NORTHERN VA - MHI	123	25	20%	**425**
PIEDMONT GH	155	15	9%	**262**
SOUTHERN VA - MHI	75	17	22%	**266**
SOUTHWESTERN - MHI	156	7	4%	**103**
WESTERN STATE	253	16	6%	**112**
TOTALS	1459	154	10%	
			AVERAGE	**280**
			MEDIAN	**186**

Findings from Review of the NVMHI Budget and Operations

As summarized in Background section (and shown in detail in Appendix A-1), the CSBs of the region considered the beds proposed for closure at NVMHI to be so important to the citizens of their communities that they have used CSB funds (mostly local and state LIPOS funds, amounting to $1,150,000 in FY11, $1,623,000 in FY12, and $800,000 for FY13) to keep them open in FY11, FY12 and FY13. DBHDS, when it was able to do so, also allocated one-time funds from various sources to help keep these beds open. It is neither reasonable nor appropriate to expect the CSBs to continue to divert funds intended for community services to support a DBHDS facility. Northern Virginia CSBs, as noted widely in the press, have also been subjected to cuts of local funds. The CSB funds that are now being used to support NVMHI should be redirected to support their intended use for community inpatient services and other supports that would decrease pressure for use of NVMHI.

As part of this study, an extensive review of NVMHI's budget and operations was completed by DBHDS, including a team of budget and program specialists from central office and four other DBHDS hospitals. These findings are summarized below.

7. ***Staffing and operations at NVMHI can be reconfigured to come more into line with other DBHDS facilities, and these measures will reduce the additional funding needed to operate the full capacity of 129 beds to $1,400,000, which is less than the $2,300,000 originally cut in 2009 and 2010.***

    - If the full amount of $1.4 M is not available to support 129 beds, significant cuts of support and treatment team staffing will be necessary, resulting in increased workloads for treatment staff and diminished supports for patients.

FINDINGS: REVIEW OF ALTERNATIVES TO RE-OPENING THE 129 BED CAPACITY OF NVMHI

The budget language specified that "*The Commissioner shall also assess the cost and feasibility of creating an alternative to re-opening beds at NVMHI.*"

The stakeholder committee created two subcommittees to develop alternative program models that, if funded and operational, could divert a greater number of persons from NVMHI or help persons return from NVMHI to stable community living situation, thereby reducing need for hospitalization. The series of program ideas are proven, evidence-based services that work across the country and in Virginia, including Northern Virginia. Currently, there simply is not sufficient availability and access for these programs to have the effect they could. If these services were more widely available, it would allow a significant reduction in the size of NVMHI. However, the cost and the start up time required to acquire, build, and staff program sites in the more expensive Northern Virginia area means that the development of a full system of alternatives is not practical for the next couple of years - even if efforts are started now. But, as many states have shown, with these systems of services in place, the need for state hospitals can be greatly reduced.

8. ***CSBs and private hospitals, working together, have envisioned a system of services that can dramatically reduce the need for inpatient hospitalization, including reducing the size of NVMHI, in the relatively near future, but the investment of funding and time needed to develop and implement these alternatives leaves no***

option but to continue to operate NVMHI at maximum possible capacity (preferably, 129 beds) for the immediate future.

DIVERSION ALTERNATIVES TO INPATIENT TREATMENT

As one of two subcommittees to the Northern Virginia Bed Needs Study, the Diversion Subcommittee included staff from the CSBs, NVMHI, and private hospitals who met to analyze the needs of persons who are admitted to hospitals. If additional alternatives were available for persons in crisis, then HPR II hospitals would turn away fewer referrals and all persons from HPR II could be served in hospitals in the region or, when appropriate, at less intensive diversion opportunities in the community. This subcommittee identified multiple diversion options that are listed below and in a complete document in Appendix-8. The selected services and their priorities were reviewed by additional groups, including the Regional Utilization Group, Regional Management Group, and the overall Northern Virginia Bed Needs Study Group. *The following programs were prioritized as meeting the greatest needs of persons needing admissions to hospitals in HPR II:*

a. Medical detoxification beds

Persons suffering from acute dependence on alcohol or other drugs for which withdrawal could be life-threatening need safe, medically supervised detoxification (or 'detox') in a residential setting. Many also present as feeling desperate and suicidal. If medical detoxification resources are not available, these persons may have no available resource other than a TDO to a psychiatric hospital bed, which is a higher and more costly level of care than they need. Moreover, many local (and state) hospitals resist admitting these patients because the hospitals cannot meet their medical detoxification needs. These patients may also be disruptive and difficult to serve in small private hospitals that may have difficulty mixing these patients with their current patients. A detox program would include substance use disorder/mental health specialists who could provide admissions 24/7 and manage individuals that are SMI and/or at risk for suicide as well as those in need of medically-assisted detox.

The important role of medical detox programs was underscored by the DBHDS *Creating Opportunities* strategic plan, which gave such programs the highest priority for both improving crisis response and substance abuse services. Currently, only Fairfax-Falls Church CSB has a detox facility and it is usually full. A 16 bed detox facility was projected by the subcommittee to cost $2,800,000. This program would reduce the demand for TDO beds and significantly relieve the pressures on local hospitals and NVMHI.

b. Specialized psychiatric emergency department with capacity for police transfer of custody and 23 hour beds

Persons in crisis often have complex needs and require a thorough assessment to determine the best disposition alternative. They also need time, attention, clinical intervention, and peer support in a safe setting for anxiety and distress to subside so that they can be transitioned to stable, ongoing care in the community. A CSB office or the emergency room of a hospital is not the ideal place to make these complicated and nuanced decisions, or to produce calm and stability in the person. The individuals experiencing these crises are often well known to the CSBs, hospitals and law enforcement. As with the medical detox program described above, these are the very persons for whom finding a psychiatric hospital bed is most difficult. Hospital (or jail) services are often not the most cost effective or appropriate for many of these persons.

A specialized psychiatric reception and assessment center, supplied with comfortable lounge chairs and adequate staff, can offer a calming environment to allow for individuals in crisis to be evaluated, supervised and stabilized over an extended period of time. (In Northern Virginia, only Arlington has elements of this approach, though it has limited capacity and does not yet accept persons detained by the police.)

This site can also serve as a "police drop off" point for persons taken into police custody for unlawful behavior that relates to or stems from their behavioral health needs. Jails and hospitals are often the final destinations for these persons, after long periods of detention in emergency rooms, which tie up law enforcement personnel and pull them from public safety duties. CSB jail diversion case management teams would provide services adults who have been diverted from the criminal justice system or who are risk of future criminal justice involvement.

These individuals would be brought by the police to the center where intake, intensive case management, short term treatment, outreach and discharge planning would be provided. The primary focus would be on intensive, wrap-around case management services, advocacy and successful linkage to ongoing mental health and community services. Crisis stabilization and medication services provided via emergency services would be an essential component of the early treatment services offered to these clients. Many individuals may be existing clients already enrolled in CSB services, or they may be new to the system, but staff would closely coordinate and collaborate with a wide range of other service providers including crisis care, homeless shelters, and residential services. A critical component would be linkages to multiple other agencies such as Social Security Administration, Department of Family Services, Department of Housing, Health Department, faith-based groups and Department of Rehabilitative Services. Liaisons with each agency would need to be established upon the inception of the program.

Early identification of individuals at risk who are arrested secondary to their mental illness would enable providers to stabilize these persons early enough in the crisis to avert hospitalization. Costs for such a program range from $670,000 to $2,000,000, depending on size, security levels, and location costs. In any case, the average costs per bed would be significantly lower ($300/day) than costs to place persons in private hospitals with LIPOS (approximately $900/day in Northern Virginia)

c. **In-home crisis stabilization**

Many times the best place to provide supports for persons in crisis is where the person is located. Program models exist in Virginia in which both clinical and peer support staff (persons in recovery themselves from mental illness who have been trained to support others) go to the individual's home or wherever the individual may be located to meet and assess the need for services, wrap-around services and supports for the person, help to calm the individual and links to other supports. This can occur in the person's home, a shelter or any residential setting (group home, shared apartment, ALF, etc). The team would provide crisis stabilization and support to the individual and assist others in the setting to manage and stabilize the individual. This does not require 24/7 supervision and may or may not include psychiatric consultation and care.

Many disposition options are available through this approach. For example, the individual may be encouraged to enter one of the region's crisis stabilization programs or assist in the development of a plan for clinical staff to provide home visits and orchestrate treatment. The team might assist in the development of coping skills, provide recovery information, take the person to medication

appointments and provide whatever coordination of services might be needed to assist in averting hospitalization. Such services are Medicaid reimbursable when applicable. Services would extend for 15 days.

Costs for such a service vary by size and frequency of use. The Region II subcommittee developed a base budget of $334,000, to serve 230 persons per year, or multiples thereof to serve more persons, more areas of the region, etc.

These three services described above – medical detox, specialized psychiatric emergency rooms and in home crisis stabilization - are the priority items identified by the subcommittee. A complete listing of options considered by the stakeholder group is included in Appendix A-8.

DISCHARGE AND COMMUNITY SUPPORT ALTERNATIVES TO INPATIENT TREATMENT

The second subcommittee to the Northern Virginia Bed Needs Study, the Discharge Subcommittee, included staff from the CSBs, NVMHI, and private hospitals who met to review the discharge needs of hospitalized persons. If barriers to discharge are reduced, then shorter lengths of stay, greater flow through of available beds, and more available bed capacity for admissions will accrue. This subcommittee identified multiple barriers that are listed in detail in Appendix A-9. This plan was reviewed by additional groups, including the Regional Utilization Group, Regional Management Group, private hospital e-mail distribution groups, and the overall Northern Virginia Bed Needs Study Group. The following programs were prioritized as being the most effective in meeting the greatest needs of persons leaving hospitals in HPR II:

a. Enhanced Intensive Community Residential Treatment (ICRT)

DAP (discharge assistance planning) funds have assisted many individuals receiving services at NVMHI in achieving discharge and successful community placement. DBHDS considers DAP to be the single best way to "unblock" the state hospital system by helping longer term patients leave the hospital and thus freeing up capacity to n accommodate many more shorter-term admissions. Those remaining individuals receiving inpatient services who have been on the EBL (extraordinary barriers to discharge list) for an extended period have a considerably higher level of need. Their higher levels and complexity of needs and the limited availability of the housing and supports to meet their needs are the "extraordinary barriers" that keep them in the hospital. DAP packages for them will cost more than the average to date and new services that do not now exist will have to be created to meet their needs. DAP plans for persons with similar needs can support new programs such as intensive community treatment residences. There are two such programs now in Northern Virginia. HPR II needs funding for two enhanced ICRT eight-bed programs, where more intensive staffing and specialized programming is available. This enhanced program with additional funding for nurses and behavioral specialists would be able to address the unique medical and behavioral needs of persons who currently cannot be served in the community. Costs for one ICRT program are estimated to be $1,220,000.

b. Transitional housing with supports

Housing presents an enormous challenge to persons in Northern Virginia, particularly for the more vulnerable persons who are planning to be discharged from NVMHI. Consumer groups, the DBHDS *Creating Opportunities* strategic plan, and the Governor's Homeless Outcomes Coordinating Council all rate the creation of housing with appropriate clinical and community supports as the highest priority for community needs for persons with mental illnesses. Transitional housing –

mostly rental payment assistance for single occupancy apartments – would also be a resource for persons who have utilized existing treatment settings, such as ICRTs, but no longer need that level of intensity. A continuum of transitional housing would provide options for persons leaving NVMHI who may need more intensity upon discharge but can transition to a lower level of care, thereby freeing up more intensive housing for other persons being discharged from NVMHI. The supports for persons needing them to be successful in their own apartments are best exemplified by the Intensive Community Treatment (ICT) model, which is similar to, but less formally structured than PACT – the well known program of assertive community treatment that has been called a "hospital without walls." A housing support program would not only let many persons leave the hospital successfully, but would reduce the likelihood that people would experience psychiatric crises leading to hospitalization and the dissolution of their former housing arrangements (broken leases, damages, ejection and refusal to return from ALFs, etc). Housing rental assistance and an ICT-level of community supports for 125 persons would cost $1,562,000 per year.

ALTERNATIVES FOR PERSONS WHO ARE NGRI

Approximately 30 persons at NVMHI have been adjudicated Not Guilty by Reason of Insanity (NGRI) (average census of NGRI patients was 28 persons in FY12, 30 in FY11, and 31 in FY10). Several of these persons have been at NVMHI for two to three years, and several are psychiatrically stable, working in the community, and not needing an acute level of care. However, they remain in the hospital because the court review process has been prolonged. Currently, many could be conditionally released if a sound and appropriate housing, clinical services, and community support plan could be put together and presented to the courts. The solutions described above, especially the housing supports and placement in specialized ICRTs that could serve eight persons would allow these persons under NGRI status to be served in a setting that matches their clinical presentation and would also free up hospital beds for persons with acute needs. These programs would be a high priority for the use of the DAP, ICRT, and housing/supports packages described above, if funded.

IV. CONCLUSION AND RECOMMENDATIONS

The DBHDS study of NVMHI bed capacity needs establishes that restoration of funding for public beds at NVMHI is critically needed and that alternatives to inpatient services are lacking in capacity. It is recommended that:

1. NVMHI be restored to its original (pre-2010) operational capacity of 129 beds, requiring an annual increase in allocated state general funds of $1,400,000 per year, beginning on July 1, 2013.
2. The Region II CSBs redirect 100% of the state general funds that are granted to individual CSBs and the Region for local inpatient purchase of service (LIPOS) and other inpatient diversion services to the purposes for which they were originally granted in order to decrease pressure for use of NVMHI.
3. Expanded program capacity designed to reduce the reliance on inpatient hospitalization be implemented in Region II on a continuing basis as soon as funding can be made available for this purpose.

APPENDICES

APPENDIX A-1

NVMHI Budget Chronology FY08 - FY13

		FY08	FY09	FY10	FY11	FY12	FY13
# Of Operating Beds		129	129	129	123	123	123
Original budget Appropriation		27,689,789	27,689,789	27,689,789	27,689,789	25,888,617	25,412,121
Summary of Budget Reductions							
Budget Reduction made 9/10/2009				(1,312,422)	(1,312,422)		
Budget Reduction made in 10/2009				(488,750)	(488,750)		
FY12 budget reduction made in May 2010						(491,721)	
	Total Reductions	0	0	(1,801,172)	(1,801,172)		
Final Base Budget Appropriation		27,689,789	27,689,789	25,888,617	25,888,617	25,396,896	25,412,121
Additional Funding from DBHDS, HPR II, and the Legislature for FY10-FY13							
1	Additional Budget funding from CO in March			600,000			
2	HPR II contribution for After Hours PCP coverage			245,000			
3	HPR II contribution for high cost discharge meds			33,000			
4	DBHDS payment of FY11 Insurance Prepays on NVMHI's behalf			211,000			
5	HPR II purchase of 13 operating beds FY11-FY13			0	1,150,000	1,623,000	800,000
6	One time funding received from the General Assembly for FY13						600,000
Total Operating Funds Available		**27,689,789**	**27,689,789**	**26,977,617**	**27,038,617**	**27,019,896**	**26,812,121**

Acute Care Hospitalization and the Role of Northern Virginia Mental Health Institute
Northern Virginia Regional Management Group
April 6, 2012

Background

- Over the past ten years, the Northern Virginia Regional Management Group which is comprised of the five Community Services Boards (CSB), Northern Virginia Mental Health Institute (NVMHI) and the Northern Virginia Training Center (NVTC) has worked closely to create a service plan that makes the most efficient use of available resources both in the community and at the facility
- This planning and coordination has resulted in the lowest per capita use of acute care psychiatric hospital beds by a the public sector in the state
- About two years ago, in response to a state budget reductions, the Department of Behavioral Health and Developmental Services (DBHDS) decided to close 19 admission beds at NVMHI out of the 38 that were available. This decision was not made in consultation with the regional CSB leadership
- In response to that reduction, the Regional Management Group has used existing regional funds to maintain 13 of the 19 beds that were no longer funded in the state budget
- This year, the region does not have sufficient funds to maintain the 13 beds but may receive a one-time $900,000 allocation from the current budget deliberations that with some regional funding match would keep the 13 beds available for one more year
- The region will be adding 9 more crisis stabilization beds to the 26 that are available at three sites in this region. Those new beds will be available in early Fall.

Current Issue

- The Northern Virginia CSBs are experiencing local reductions at a significant level. This has a significant impact on all services because of the amount of local funding support
- The populations that are admitted to the NVMHI are those people whose needs are complex and who are not generally accepted by private community hospitals in Northern Virginia
- Local hospitals are not interested in expanding their role, especially in this economy. The latest example is that Inova-Fairfax closed their six adolescent psychiatric beds because they did not want to invest in the licensure requirements to maintain them
- Those local hospitals that do expand, are primarily doing that to respond to larger market needs, not to accommodate CSB referrals
- While no specific business plans have been established as alternatives to re-establishing the NVMHI 19 beds, the overall cost of any alternative would not be much less
    - Contracting all or part of the NVMHI management to a private sector entity
    - Creating an NGRI residential program in the community and using those beds at NVMHI for admissions
    - Specifically contracting with a private vendor to establish bed capacity that would address the needs of the NVMHI admission beds.

Discussion

- What strategy or direction is the state taking in building the acute hospitalization bed capacity in the Northern Virginia?
- What is the long-term strategy for addressing the needs of this population?
- What is the plan for using the NVMHI facility and specifically is there any planning around alternative uses?
- Would the state be able to commit resources if the local CSBs can develop a sound proposal for alternative uses or strategies to use the facility or serve the growing needs of this population?

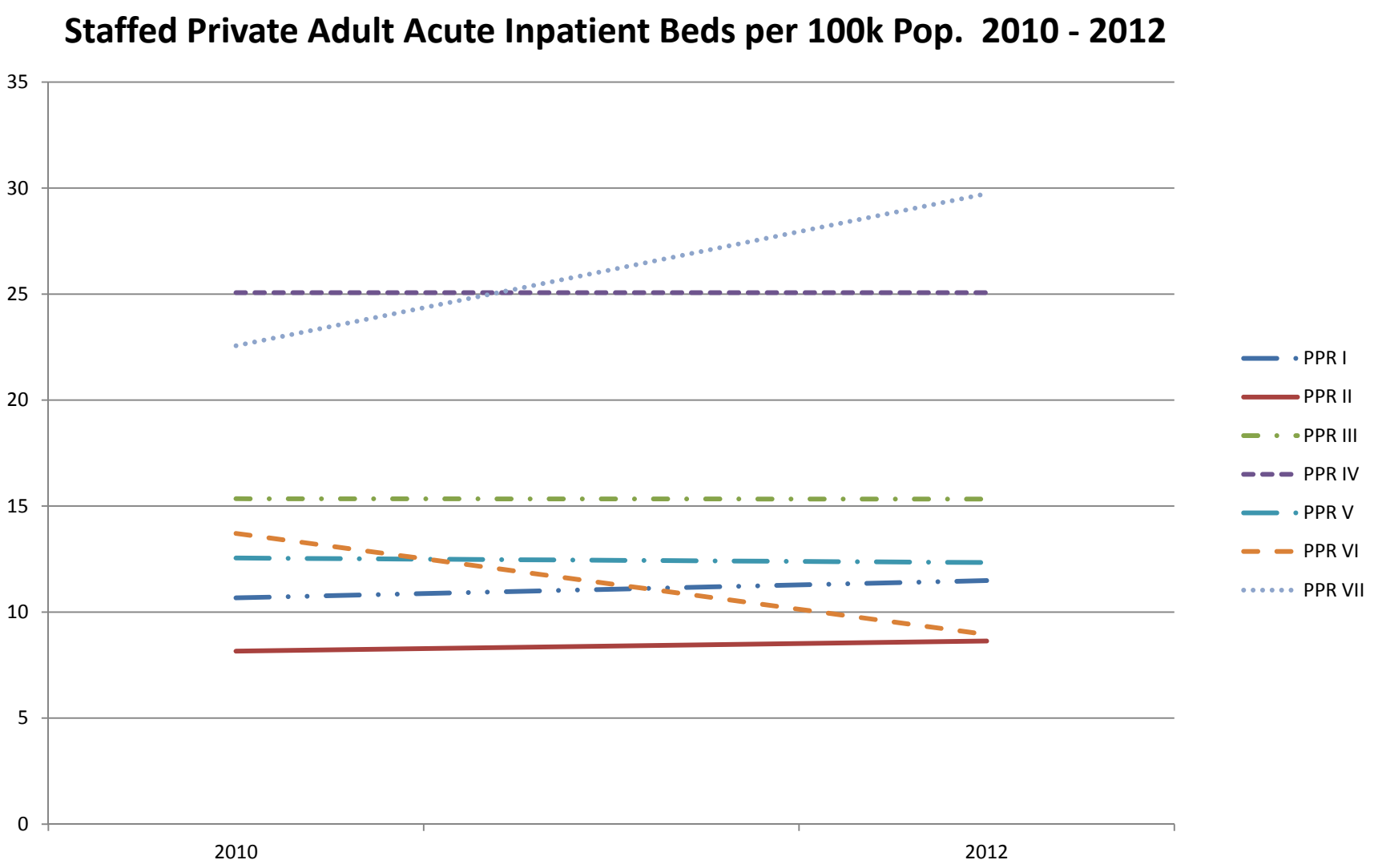
APPENDIX A-3

DBHDS Northern Virginia Mental Health Institute
Bed Capacity Study

Study workgroup meetings were held on the following dates:

- June 7, 2012
- June 29, 2012 (teleconference)
- July 10, 2012
- July 25, 2012

WORKGROUP MEMBERSHIP	
Study Workgroup Member	**Affiliation**
John Pezzoli	DBHDS
Sterling Deal	DBHDS
Michael Schaefer	DBHDS
William O'Bier	DBHDS
Jim Martinez	DBHDS
Michael Shank	DBHDS
Russell Payne	DBHDS
David Lyon	NVMHI Facility Director (acting)
Melissa Preston	NVMHI Social Work Director
Maximilien Del Rio	NVMHI Medical Director
Cynthia Koshatka	Northern Virginia Regional Projects Manager
James Kelly	Fairfax CSB
Kay Dicharry	Loudoun CSB
Beth Dugan	Prince William CSB
Leslie Weisman	Arlington CSB
Lyannne Trumbull	Fairfax CSB
Cindy Kemp	Arlington CSB
Betty Long	Virginia Hospital & Healthcare Association
Mark Howard	Mary Washington Hospital (Snowden)
Charles Scercy	Mary Washington Hospital
Kent Alford	HCA Healthcare
Laura Howerton-Burns	Virginia Hospital Center
Marilyn Paysle	Arlington CSB
Keith Lisenbee	Dominion Hospital
Sally Drapper	Fairfax Hospital
Shirley Repta	Inova Hospital
Richard W. Clark	Poplar Springs Hospital, CEO
Kate Marshall	Catawba Hospital
Charles Law	Catawba Hospital
Ann Bailey	Central State Hospital
Cynthia McClaskey	Southwestern Virginia Mental Health Institute
Jack Barber	Western State Hospital
Aleisha Manson	Piedmont Geriatric Hospital
Ann Bailey	Central State Hospital
Jack Wood	Eastern State Hospital
Christine Armstead	Eastern State Hospital
Joe Brown	Eastern State Hospital
Melissa Evans	Eastern State Hospital
Annie Howard	Eastern State Hospital


Staffed Private Adult Acute Inpatient Beds per 100k Pop. 2010 - 2012
35
30
25
20
15
10
5
0
2010
2012
PPR I
PPR II
PPR III
PPR IV
PPR V
PPR VI
PPR VII

APPENDIX A-5

FYO6	Admissions	Discharges	Average Occupancy	Occupancy Rate	30 day Re-admissions	*30 day Re-admissions Rate
July	48	55	125	97%	0	0%
August	59	58	125	97%	6	10%
Sept	48	53	122	95%	8	16%
Oct	50	47	128	99%	2	4%
Nov	54	54	123	95%	6	11%
Dec	58	57	123	95%	2	3%
Jan	45	48	124	96%	9	20%
Feb	32	30	123	96%	2	6%
March	43	44	124	96%	5	11%
April	49	43	123	96%	3	6%
May	45	48	127	98%	5	11%
June	71	67	125	97%	6	8%
Total	**602**	**604**	**124**	**96%**	**54**	**9%**
FYO7						
July	65	69	125	97%	8	12%
August	61	62	126	98%	7	11%
Sept	65	60	126	97%	4	6%
Oct	54	58	127	98%	2	4%
Nov	55	54	126	98%	5	9%
Dec	50	47	126	98%	6	12%
Jan	67	70	125	97%	8	12%
Feb	62	64	125	97%	7	11%
March	64	63	126	98%	7	11%
April	82	82	125	97%	8	8%
May	80	82	123	96%	6	8%
June	70	71	124	96%	7	10%
Total	**775**	**782**	**125**	**97%**	**75**	**10%**
FYO8						
July	73	74	121	94%	12	17%
August	74	74	122	95%	6	8%
Sept	63	62	118	92%	2	3%
Oct	82	80	122	95%	7	11%
Nov	57	56	126	97%	5	6%
Dec	62	62	124	96%	7	12%
Jan	72	70	122	95%	10	16%
Feb	60	61	126	97%	10	14%
March	51	54	127	98%	6	10%
April	68	71	124	96%	6	11%
May	77	72	125	97%	11	16%
June	67	71	125	97%	5	7%
Total	**806**	**807**	**124**	**96%**	**87**	**11%**

*** = Number of readmissions divided by number of discharges from previous month**

FYO9						
July	80	78		98%	5	6%
August	56	60		98%	5	6%
Sept	91	84		96%	5	8%
Oct	85	89		95%	9	11%
Nov	73	81		92%	12	14%
Dec	88	93		83%	13	16%
Jan	73	79		92%	13	14%
Feb	88	73		88%	6	8%
March	101	111		92%	7	10%
April	106	91		91%	16	14%
May	45	48		98%	5	6%
June	90	91		98%	13	17%
Total	**976**	**978**		**93%**	**109**	**11%**
FY1O						
July	81	82	30	95%	9	10%
August	84	82	31	95%	8	10%
Sept	80	86	32	98%	7	9%
Oct	77	78	29	95%	6	7%
Nov	71	67	27	97%	6	8%
Dec	96	100	28	94%	6	9%
Jan	75	78	30	95%	16	16%
Feb	85	76	30	91%	7	9%
March	94	100	33	97%	10	13%
April	89	85	34	97%	9	9%
May	75	74	35	96%	8	9%
June	78	90	34	95%	8	11%
Total	**985**	**998**	**31**	**95%**	**100**	**10%**
FY11						
July	90	94	32	96%	6	7%
August	84	82	31	92%	8	9%
Sept	89	83	32	95%	8	11%
Oct	64	60	31	98%	6	7%
Nov	75	79	29	97%	4	7%
Dec	76	74	30	97%	10	13%
Jan	68	71	30	97%	9	12%
Feb	70	68	31	96%	3	4%
March	72	76	32	97%	5	7%
April	62	60	29	98%	1	1%
May	65	68	28	97%	4	7%
June	58	63	29	93%	3	4%
Total	**873**	**878**	**30**	**96%**	**67**	**8%**

Item 319.A.2. Bed Capacity of NVMHI
November 20, 2012

FY12						
July	69	70	29	92%	5	8%
August	57	51	29	94%	3	4%
Sept	44	49	30	95%	3	6%
Oct	63	56	28	92%	4	8%
Nov	65	71	27	89%	4	7%
Dec	53	61	26	92%	11	16%
Jan	60	47	25	91%	2	3%
Feb	79	85	26	91%	3	6%
March	70	64	26	94%	10	12%
April	65	63	28	95%	8	12%
May	76	84	30	89%	7	11%
June	62	66	31	94%	7	8%
Total	**763**	**767**	**28**	**92%**	**67**	**9%**

*** = Number of readmissions divided by number of discharges from previous month**

APPENDIX A-6

ADMISSIONS DATA FOR PRIVATE HOSPITALS PROVIDING SERVICES IN NORTHERN VIRGINIA

Data is for the 12-month period from June 30, 2011 to May 31, 2012:

	Region 2 Hospitals						Other Key Hospitals		
	Dominion	**Inova Fairfax**	**Inova Mt Vernon**	**Inova Loudoun**	**Prince William**	**Virginia Hosp Ctr**	**Snowden**	**Spotsylvania**	**Poplar Springs**
Licensed beds	40 adult/52 CA/8 eating disorders	34 adult	30 adult	22 adult	32 adult	40 adult	30 adult/10 CA	10 adult	54 adult/21 CA
Staffed beds	40 adult/52 CA/8 eating disorders	34 adult	30 adult	18 adult	32 adult	35 adult	30 adult/10 CA	10 adult	54 adult/21 CA
Details associated with beds	32 beds for adolescents, 20 beds for children Unable to handle significant MR/ID patients County zoning restrictions prohibit admission of: -Patients with current or past history of violent criminal charges, -Patients under current criminal detainment (i.e. jail or juvenile detention), -Adult patients on commitment -Patients with primary diagnosis of substance abuse.	Adults > 18 yr old Criteria: acute illness exacerbation, or detox due to DSM IV diagnosis. Setting not appropriate for forensic patient, or profound ID.	Adults > 18 yr old Criteria: acute illness , exacerbation, or detox due to DSM IV diagnosis. Setting not appropriate for forensic patient or profound ID.	Specialize in geriatrics. Not appropriate for treatment of forensic patients, severe I.D.	Includes 6 beds licensed for detox with ability to flex.	17 beds are for mental health patients; 18 beds are for addiction	Patient populations unable to effectively serve: -Moderate/Severe Intellectual Disabilities -Primary diagnosis of traumatic brain injury -Infectious diseases requiring isolation -Chronic, degenerative intellectual deficits -Medically compromised	All beds are general adult 18-64. No bed reservations for clinical purposes. No restrictions for accepting patients from localities. Only restrictions for patients that fall outside of admission criteria and exclusionary criteria such as medically complex.	
Number of Admissions	2,857	1,610	1,116	674	675	261 (2011)	1,972	448	
Average Length of Stay	8.51	6	5	7.68	6.3	8.06 (Psych & SA)	5.85	5.8	

Occupancy Rate									
	Region 2 Hospitals						Other Key Hospitals		
	Dominion	**Inova Fairfax**	**Inova Mt Vernon**	**Inova Loudoun**	**Prince William**	**Virginia Hosp Ctr**	**Snowden**	**Spotsylvania**	**Poplar Springs**
% of admissions that are Self-Pay	2.7%	18%	22%	15%	39%	10% (that present discharge issues)	16%	21%	
Est. of beds days when <u>patient was ready for discharge but no viable options were available</u>	At least two patients per month remain for several days after they are ready for discharge	Estimate 730 days – on any given day, approx. 2 patients still hospitalized waiting for a crisis care bed, NVMHI, or alternative.			We estimate this occurs with about 20% of all of our patients. Some wait for weeks or months to be discharged.			Not a typical occurrence, less than 20 at most.	
Example(s) of instances where patient is ready for discharge but no viable options available	Patient ready for discharge but must taper off benzodiazepine before admission to crisis stabilization unit. No available shelter beds or housing options. Difficulty finding after care providers	Patient from group home. Group home will not accept pt back due to past behavioral issues. When stabilized began process to transfer to NVMHI for continued care. Evaluation for admission process took	Patient with history of multiple admissions at IFH and IMVH. Three admissions this year. Exhausted VA Medicaid days. Admitted and stabilized but still needing longer term treatment. On waiting list for NVMHI for weeks. Had to be re-detained.	Elderly patient with dementia not accepted by multiple nursing homes. Indigent patient with no safe discharge plan. Follow-up appt not available at county mental health for weeks.		It includes patients who come from assisted living facilities and are not allowed back; patients who require legal guardianship to manage their daily affairs; patients who are homeless; patients with repeated admissions and no ability to get a solid	Extended length of stay can be related to the following: (1) Awaiting transfer to state hospital (2) Awaiting residential placement for child/adolescent (3) Accessing CSU or shelter placement.	Occurs typically with homeless population and patients being discharged out of state.	

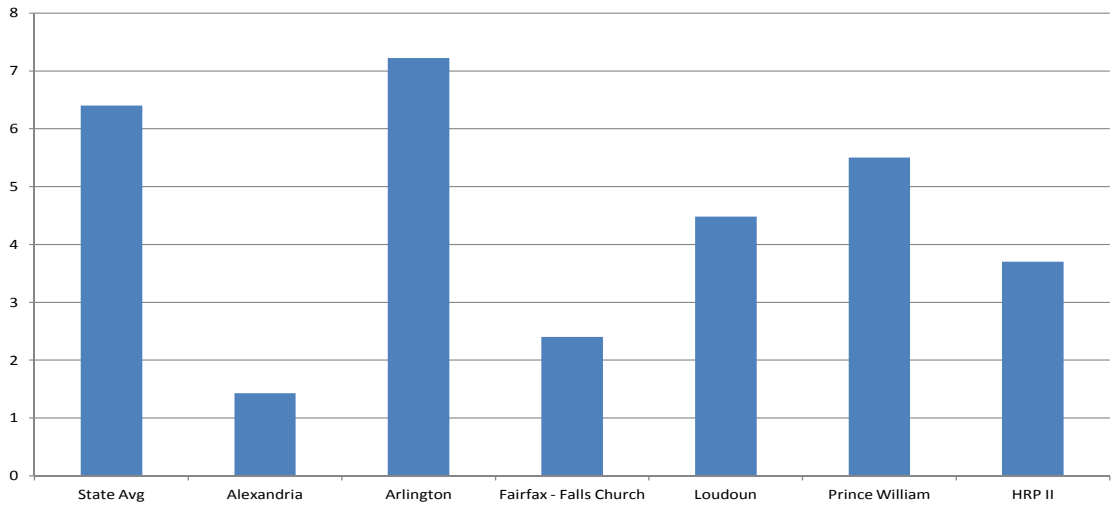
	that can provide level of care that is appropriate. Patients not allowed to return to a Crisis Stabilization Unit due to past behavioral issues. Patients can't afford long term treatment options, such as sober-living facilities.	nearly two months (had been previous NVMHI pt), then admission was denied. Pt was finally d/c'd to reluctant relative after LOS of 71 days.	So far LOS is 47 days.			discharge plan because they have exhausted the system; patients who have dementia and also a psychiatric diagnosis.			

Item 319.A.2. Bed Capacity of NVMHI
November 20, 2012

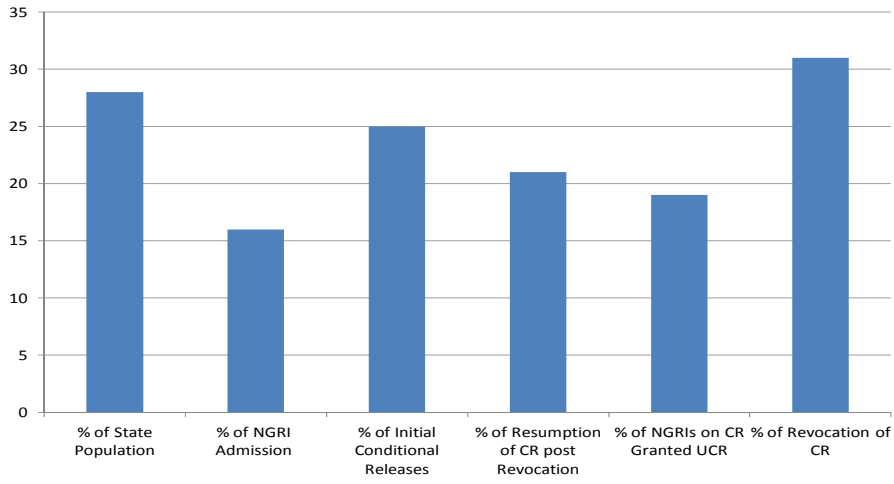
	Region 2 Hospitals						Other Key Hospitals		
Hospital Name	**Dominion**	**Inova Fairfax**	**Inova Mt Vernon**	**Inova Loudoun**	**Prince William**	**Virginia Hosp Ctr**	**Snowden**	**Spotsylvania**	**Poplar Springs**
Other information relevant to the charge of the NVMHI work group	The population of adults diagnosed with SMI that require more intensive levels of care (PACT, CSU, Supported Housing, MHSS) is beyond the community's capacity to provide. This results in increased utilization of hospitals such as NVMHI.	It would be helpful to have a streamlined, predictable admission process with clear criteria. Often involves days of waiting for an answer, then having to get the patient re-detained because commitment lapses. Beds frequently full on the "long term" unit. Do we need to increase capacity there?	Though patient meets criteria for transfer, acceptance at NVMHI is often delayed until pt has been at IMVH for 6-8 weeks.		We need those long term beds for chronic stabilization as indicated for there is little to no resources in the community.		Creation of a Navigator Service in Emergency Departments for complex case management and disposition services Access and availability to emergency respite care in collaboration with local CSB.		

APPENDIX A-7

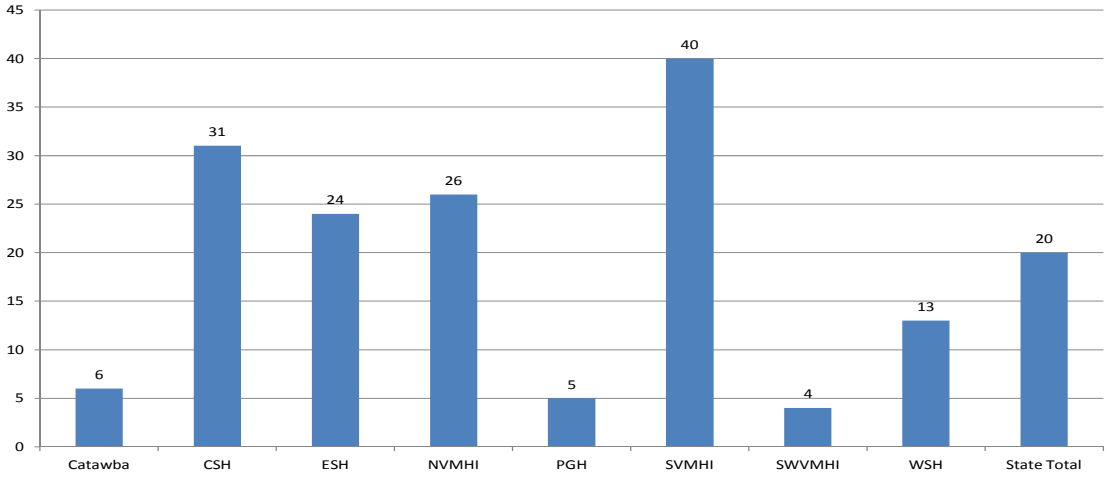
NGRI Acquittal Rate (per 100,000)
** Based on NGRI Admissions per CSB



Comparative Statistics for HPR II
Population Size vs. NGRI Data (FY '03 – FY '11)



Percentage of State Hospital Beds Occupied by NGRIs



Mean and Median LOS of NGRIs Conditionally Released in FY '10-'12

Facility	Mean LOS in Hospital for NGRIs Conditionally Released **	Median LOS in Hospital for NGRIs Conditionally Released **
CSH	2353	1607
ESH	2213	1262
WSH	2591	1380
NVMHI	1320	948
SVMHI	5339	5370
Catawba	9976	9976
SWVMHI	3602	3602
PGH	3014	3014
** Excludes NGRIs CR out of Temp Custody		

Current LOS for NGRIs Currently in Hospital

Facility	Mean LOS for NGRIs in Hospital	Median LOS for NGRIs in Hospital
CSH (Civil)	2881	1899
ESH	2934	1444
WSH	2194	1738
NVMHI	1893	1121
SVMHI	1657	1737
Catawba	4733	4187
SWVMHI	4435	2679
PGH	5520	6146

APPENDIX A-8

HPRII – Emergency Managers
Hospital Diversion Availability

The following Crisis Services are essential components in the continuum of care currently available in some jurisdictions in the community.

Crisis intervention services are mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute mental health dysfunction requiring immediate clinical attention. The objectives are:

- To prevent exacerbation of a condition;
- To prevent injury to the member or others; and
- To provide treatment in the least restrictive setting.

Crisis Stabilization Services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Enhanced Office Crisis Stabilization - Emergency Services office supplied with comfortable lounge chairs and adequate staffed to allow for individual in crisis to be supervised and stabilized over an extended period of time.

Mobile Crisis Team – MCU provides emergency assessment and treatment within the community to individuals experiencing a psychiatric crisis who are unwilling or unable to seek such services. The goals of the MCU include crisis resolution, engagement in ongoing treatment, and providing for the safety of individuals and the community.

Medical Detox – Facility/program operated of contract to provide medical detox for dually diagnoses substance abusers.

Partial Hospitalization – Contracted services through Regional office.

Day Treatment - The APH program is structured to provide both acute and intermediate care services.

- Acute services will focus on consumers who are experiencing acute psychiatric symptoms. Acute care services will target consumers discharged from inpatient hospitalization, crisis care step down and those consumers at risk of hospitalization and involved with emergency services.
- Intermediate services will focus on consumers who need more intensive services than outpatient level of care to avoid hospitalization. These consumers may be engaging in para-suidical behavior and/or demonstrating signs of increased symptom presentation but do not meet the criteria for inpatient hospitalization.

PACT –

ICT –

Services Offered by Each CSB

	Fairfax	Prince William	Arlington	Alexandria	Loudoun
Crisis Intervention	X	X	X	X	X
Crisis Stabilization	X	X	X	X	X
Enhanced In-Office Crisis Stabilization			8am-10pm		
Mobile Crisis Team	X		X	X	
Medical Detox	X	To some extent		To some extent with Alexandria Hospital	
In-home Crisis Stabilization					
Partial Hospitalization	X	X	X	X	X
Day Treatment	X	Not Acute	X	X	
Tele-Psychiatry	X				X
PACT	X		X		
Intensive Crisis Teams ICT		X			X
Transportation				X	

Hospital Diversion Prioritization

The following interventions have been prioritized as possible target intervention by HPRII. The services are either not currently available or are only partially available at each CSB. Their importance in diverting individuals from hospitalization cannot be overstated.

Enhanced 23 Hour Beds

Emergency Services Location - Offer calming room supplied with comfortable lounge chairs and adequate staff to allow for individual in crisis to be supervised and stabilized over an extended period of time.) `New Fairfax County Mid-County Human Services Building scheduled opening 2014

Personnel	**Grade**	**FTEs**	**Salary**	
Psychiatrist	S25	0.5	$135,519	
Nurse	S24	1	$94,165	
Clinicians	S26	5	$280,295	56059
Peer	S14	5	$160,330	32066
		Total Cost	**$670,390**	
3 calming rooms and 3 suites Total 6		Does not include facility, utilities food etc..		

Bed Day Costs: $306 Bed Day
670390 / 365 =183 /6 306 X .85 161
NVMHI – Unit Conversion

Plan A: Cost Estimate for HPR II Operating Six Beds *(23 Hour)* at NVMHI F2 Admission Unit

3/25/2011	Startup One-time Expense	Notes	Ongoing/Annual Expense	Notes
Personnel (Salary and Fringe Benefits)				
Behavioral Health Nurse Supervisor (1 FTE)			$ 96,313.00	24/7 Coverage
Behavioral Health Nurse Clinician/Case Mgr (5 FTE)			$ 438,879.00	
Crisis Intervention Supervisor (1 FTE)			$ 88,427.00	24/7 Coverage
Crisis Intervention Specialist/Prescreener (6 FTE)			$ 490,947.00	
Psychiatrist (2 FTE)			$ 435,319.00	9.5 hours/day (12pm - 9:30pm)
Community Liaison Supervisor (1 FTE)			$ 81,824.00	9.5 hours/day
Community Liaison (1FTE)			$ 73,108.00	(8am - 5:30pm)
Peer Specialist/Intensive Case Manager (6 FTE)			$ 303,188.00	Three 9.5 hour shifts/day 9am - 6:30pm 11:30am - 9pm 1:30pm - 11pm
Program Manager (1 FTE)			$ 92,608.00	Monday - Friday (8:30am - 5pm)
Management Analyst I (.5 FTE)			$ 31,770.00	Monday - Friday (8:30am - 5pm)
Admin Asst. III (1 FTE)			$ 50,531.00	Monday - Friday (8:30am - 5pm)
Subtotal Personnel Expenses			**$ 2,182,914**	
Ancillary Services (Through Inova Fairfax Hospital)				
Pharmacy Services			$ 69,849	Inova Fairfax Hospital charges
Pathology			$ 2,325	Inova Fairfax Hospital charges
Radiology			$ 1,866	Inova Fairfax Hospital charges
EEG/EKG			$ 584	Inova Fairfax Hospital charges
Central Medical Supplies			$ 3,933	Inova Fairfax Hospital charges
Subtotal Ancillary Services			**$ 78,557**	
Professional Support Services				
Staff Development			$ 27,200	Estimate for training, travel, etc.
Interpreters			$ 2,791	Proportional cost for 6 beds
Vouchers			$ 15,600	Temporary housing expense, hotel, etc
Discharge Planning			$ 5,000	Food, clothing, med co-pays, bus tokens, etc.
Subtotal Professional Support Services			**$ 50,591**	
General Support Services				
Power Plant - Utilities			$ 51,329	Proportional cost for F2 Unit
Housekeeping			$ 58,399	Proportional cost for F2 Unit
Human Resources			$ -	HR admin provided by FFX
Transportation			$ 40,000	Estimate for cabs, bus, etc.
Vehicle			$ 9,000	Compact car rental, fuel, etc.
Local Travel			$ 7,956	Staff mileage reimbursement
Security Services			$ 262,800	Estimate for 24 HR security - Securitas
Physical Plant/Buildings and Grounds			$ -	Negotiate with DBHDS
Computer Services (IT)	$ 53,500.00	Staff PC's, network install, etc.	$ 45,424	Proportional VITA charge (10 PCs)
Supplies	$ 4,000.00	Initial supply	$ 8,000	Office supplies, ink, consumables, etc.
Equipment/Furniture	$ 45,000.00	Furniture, etc.	$ 3,000	Replacement/Repair
Telecom (Landline/Cell Phones/Blackberries/Fax)	$ 15,875.00	Telecom equipment purchase, infrastructure installation	$ 7,152	10 phones, 1 fax, 3 BBs, 6 cell
Postage/Mailing			$ 3,000	Estimated cost for department
Laundry and Linen Services			$ 5,337	Proportional cost for 6 beds
Food Services			$ 59,457	Proportional cost for 6 beds
Medical Records			$ 13,325	Proportional cost for 6 beds
Subtotal General Support Services	**$ 118,375.00**		**$ 574,179.55**	
TOTAL EXPENSES	$ 118,375.00		$ 2,886,242	

Budgetary Decisions to be Determined

Colocated with INOVA

Plan B: Cost Estimate to HPR II for Providing Six Beds *(23 Hour)* at Inova Fairfax Hospital

3/24/2011	Startup One-time Expense	Notes	Ongoing/Annual Expense	Notes
Personnel (Salary and Fringe Benefits)				
Crisis Intervention Supervisor (1 FTE)			$ 88,427.00	24/7 Coverage
Crisis Intervention Specialist/Prescreener (6 FTE)			$ 490,947.00	
Community Liaison (2 FTE)			$ 146,214.00	9.5 hours/day (8am - 5:30pm)
Peer Specialist/Intensive Case Manager (6 FTE)			$ 303,188.00	Three 9.5 hour shifts/day 9am - 6:30pm 11:30am - 9pm 1:30pm - 11pm
Program Manager (1 FTE)			$ 92,608.00	Monday - Friday (8:30am - 5pm)
Management Analyst I (.25 FTE)			$ 15,885.00	Monday - Friday (8:30am - 5pm)
Admin Asst. III (.5 FTE)			$ 25,266.00	Monday - Friday (8:30am - 5pm)
Subtotal Personnel Expenses			**$ 1,162,535**	
Ancillary Services				
Pharmacy Services*				
Pathology*				
Radiology*				
EEG/EKG*				
Central Medical Supplies*				
Subtotal Ancillary Services				
Professional Support Services				
Staff Development			$ 27,200	Estimate for training, travel, etc.
Interpreters			$ 2,791	Proportional cost for 6 beds
Vouchers			$ 15,600	Temporary housing expense, hotel, etc.
Discharge Planning			$ 5,000	Food, clothing, med co-pays, bus tokens, etc.
Subtotal Professional Support Services			**$ 50,591**	
General Support Services				
Power Plant - Utilities*				
Housekeeping*				
Human Resources			$ -	HR admin provided by FFX
Transportation*				
Vehicle			$ 9,000	Compact car rental, fuel, etc.
Local Travel			$ 7,956	Mileage reimbursement
Security Services*				
Physical Plant/Buildings and Grounds*				
Computer Services (IT)*				
Supplies*				
Equipment/Furniture*				
Telecom (Landline/Cell Phones/Blackberries/Fax)*				
Postage/Mailing*				
Clothing*				
Laundry and Linen Services*				
Food Services*				
Medical Records*				
Subtotal General Support Services	$ -		**$ 16,956.00**	
TOTAL EXPENSES	$ -		**$ 1,230,082**	

It is anticipated that this expense will be incorporated into Inova's costs and thus not factored into this estimate.

Budgetary Decisions to be Determined

In Home Crisis Stabilization – Emergency Services Team ideally staffed by peers that would provide Crisis supports in the home, shelter or any county operated residential setting. Team would provide crisis stabilization and support to the individual and others in the setting to assist in the management and stabilization of the individual. Does not have to be 24/7 supervision nor include psychiatric care.

Crisis Stabilization Program Middle-Peninsula-Northern-Neck
Mixture
Two Crisis Stabilization programs

- Discovery I 5 male crisis beds and 2 male discharge beds
- Discovery II 5 Female crisis beds and 2 female discharge beds

Peers assist in Recovery Education
"Peer Bridge" assigned to individual for step down/transition to home from the hospital.

In Home Crisis Stabilization
One or two clinicians go to individuals home or where ever individual may be located to meet and assess need for services. Based on assessment, individual may be encouraged to enter one of the Discovery Crisis Stabilization programs or assist in the development of a plan for clinical staff to provide home visits and orchestrate treatment. Will assist in the in development of coping skills, provide recovery information, take to medication appointments and provide whatever coordination of services may be needed to assist in adverting hospitalization.

Services are available both current and new clients to the CSB. Will provide outreach to individuals identified in the community as possible candidates for services

Medicaid reimbursed – Bill hourly increment - Can receive services up to 15 days
Will transport to appointments and provide/assist with whatever might be needed to reduce stressors and help organize individual.

In home/community services to be made available 16hrs day. Figure below capacity – would be flexible

Personnel	**Grade**	**FTEs**	**Salary**
Nurse	S24	1	$94,165
Clinicians	S26	2	$112,118
Peer	S14	4	$128,264
		Total Cost	**$334,547**
Does not reflect potential Medicaid reimbursement		Unknown # of individuals potentially served	

Enhanced Medical Detox
Detox with mental health specialist providing admissions 24/7 and capable of managing individuals that are SMI and/or at risk for suicide. Figures below assume capacity of 16 – 20.

Personnel	**Grade**	**FTEs**	**Salary**[1,2]
Program Manager	S 28	1.0	$113,642
Nurse Practitioner	S 27	2.0	$271,239
Internist	S 35	1.0	$230,042
Psychiatrist	S 25	0.5	$135,519
Nurse Supervisors	S 35	2.0	$206650
Registered Nurses	S 24	11.0	$1,035,687
Clinical Supervisor	S 26	1.0	$103,325
Clinicians	S 23	5.0	$448,174
Food Supervisor	S 16	1.0	$61,954
Cook	S 11	1.0	$51,503
Subtotal			$2,657,735
Operating			
Facility (rent/mortgage)	As both Fairfax Detox and Crisis Care are in County owned buildings, there is no charge for the facility, utilities or telecommunications		
Utilities			
Telecommunications (to include IT, phones, copiers, fax, etc)			
Cleaning Service	Crisis Care $171,804 Detox $272,367		
Vehicles (payment/lease) Gas/Maintenance/Repairs			
Food			
Medications			
Mileage			
Supplies – Office, facility, etc, etc			
Total	**$2,820,539 - $2,921,102** (Does **not** include facility, utilities and telecommunications)		

[1]Includes Fringe Benefits, a requirement when budgeting for positions in Fairfax County.
[2]Because Fairfax County has the poorest salaries among the Region II CSBs, all positions – except for the MDs and NPs were budgeted at "mid-point" (rather than "entry"). The MDs and NPS were budgeted at "maximum" as that is what we currently pay and, even then, it is exceedingly difficult to find anyone interested.

Bed Day Cost At Detox $385.

Tele-psychiatry

- **Alexandria** Does not have any tele-psychiatry/ telemedicine services as defined. They do have some capacity developed for use with commitment hearings, but it has not been used for telemedicine.
- **Fairfax-Falls Church** ES uses the Tandberg equipment for telemedicine and other evaluations including Crisis Care admissions and risk assessments.
- **Arlington** has none.
- **Prince William** CCS is not using any teleconferencing technology and never has. The barrier to using it now revolves mostly around making decision regarding what system would be best to purchase. Do we try to dovetail with the current equipment/systems currently in place, or, would we rather go with a system that is different, but, which seems to be best for various parties in our region to use. Cost may also be an issue.

- **Loudoun** One psychiatrist utilizes telemedicine to provide med follow up for Loudoun patient housed a regional jail facilities. Telemedicine equipment is occasionally used for assessment and consultation regarding Loudoun people at distant hospitals, e.g., CCCA, Catawba. We have also used the equipment between the Loudoun MHC and NVMHI. Use of equipment has been "piloted" for evaluations of youth at the Juvenile Detention Center. The psychiatrist did not find this approach clinically preferable and chose to use it only when circumstances, e.g., infection control, safety issues, necessitated.

Pricing Strategy:
Emergency Telepsychiatry pricing is blend of a fixed monthly fee and a fee for every video encounter conducted within a given month.

Pricing Explanation
Pricing is essentially based off of two values; a fixed availability fee which will stay the same from month to month and a per evaluation fee. The fixed fee allows for 24/7/365 access to the psychiatrists via phone and video as well as the services of our Access Center, and IT support. The per evaluation fee is only charged when a televideo encounter is necessary, as some communication can be done via telephone consult. We believe that this distinction empowers CSBs to control their costs while giving them access to quality mental health care.

The table below illustrates how those fees are grouped into levels based on a range of evaluations. This table is meant to give you a snapshot of our pricing levels. We can give you more specific data if your estimate for monthly calls falls somewhere outside these levels.

24/7/365	Level 3	Level 2	Level 3	Level 4
Televideo Calls P/Month	16-22	23-31	32-42	43-55
Fee Per Evaluation	$164	$158	$150	$141
Monthly Availability Fee	$7,261	$9,732	$12,558	$15,623
Availability Fee Credit/Eval*	($330)	($314)	($300)	($284)
Fee Per Eval above cap**	$472	$449	$425	$402

* If actual volume is less than the minimum range of evaluations, a credit for every evaluation below the minimum will be applied to invoices
** *Emergent evaluations that are conducted beyond the cap of the designated level will be conducted and invoiced at this rate*

Jail Diversion

The jail diversion case management team (JDCMT) will provide services to seriously mentally adults who have been diverted from the criminal justice system or who are risk of future criminal justice involvement. These individuals will be brought by the police to Woodburn CIT and may be existing clients who are already enrolled in CSB services, or new to our system. Treatment services provided will include the provisions of intake, intensive case management, short term treatment, outreach and discharge planning. The primary focus will be on intensive, hands-on, wrap-around case management services, advocacy and successful linkage to ongoing mental health and community services. Crisis stabilization and medication services provided via Emergency Services will be an essential component of the early

treatment services offered to these clients. The staff will closely coordinate and collaborate with a wide range of other service providers including the SAI, crisis care, homeless shelters, residential services, IRTT as well as ADS and MR services. A critical component will be linkages to multiple other agencies such as Social Security Administration, Department of Family Services, Department of Housing, Health Department, Faith-based groups and Department of Rehabilitative Services. Liaisons with each agency will need to be established upon the inception of the program.

Response to referrals will be prompt and flexible but in generally occur in this manner. Police will divert individuals to Woodburn CIT. WBC ES staff will conduct an initial assessment and triage, they may refer the individual to an inpatient psychiatric hospital, detox, crisis care, home, etc. Monday through Friday, WBC ES and JDCMT will staff all diverted cases from the previous 24 hours and decisions will be made as to which clients will be picked up by the JDCMT. Referrals may also be made directly to the JDCMT; at the point of initial assessment; if a member of the team is on-site able to accept a referral.

It is anticipated that the JDCMT will keep the primary case management responsibility for approximately one month. This will allow for flow-through and the ability to accept new referrals. The transfer to ongoing mental health services will be a closely coordinated transition process and individualized to each clients' needs.

It is believed that through the early identification of individuals at risk being arrested secondary to their mental illness individuals may be stabilized early enough in the crisis to advert hospitalization

Fairfax County Jail Diversion 2011
Total Served 362

Considered for Arrest = 45		12.4%		
Outcomes				
Total Hospitalizations	170	47%		
	Voluntary	40	11%	
	Involuntary	130	35.9%	
Crisis Intervention	138	38.1%		
Detox	3	0.8%		
Crisis Care	11	3%		
Refused Services	4	1.1%		
Arrested	1	1.1%		

Transportation
In a small number of cases, ECO's and TDO's are obtained because an individual cannot be safely transported to Crisis Stabilization facilities. Contracting services with an ambulance company familiar with mental health issues might assist with redirect some of these individuals to crisis stabilization facilities rather than the hospital.

Other Identified Issues in Private Hospital Sector
Easy access to Psychiatric Units through ED

- ED's interested in expediency in disposition – Want to move individuals out of ED's quickly
- MD's liability concern discharging individual who spoke of suicide

COST - CSB provides training

Coordination of Services

- Information exchange on emergency basis to assist in continuity of individual care and sharing of information to provide for crisis presentation either in ED or the ECB
- Discharge planning cooperation for insured folks who are viewed as needing services through the CSB

Regionally sponsored patient care meetings for those identified as being high risk for re-hospitalization

Appendix 9

Northern Virginia Bed Study: Post-Discharge Needs
July-August 2012

Need	Barrier	Potential solutions
Placement needs:		
• Intensive Community Residential Treatment (enhanced)	Persons have failed in our most intensive community settings due to challenging behaviors and/or medical complications	Residential settings with intensive supports, including one-to-one as needed; specialized services for medical and behavioral issues
• Continuum of transitional housing to supervised apartments w/ MH services	Persons need housing with supports as they stabilize, apply for entitlements, etc. so that re-admissions are less likely	Funding for service continuum
• Non-hospital setting for NGRIs	Persons with NGRI may be ready to be in the community but FRP or Judge may not be ready to put them on Conditional Release	Specialized placement for persons with NGRI
• Nursing home (enhanced) placements	Nursing homes are hesitant to accept persons with MH history	Add MH component to some nursing home settings
• ALF (enhanced)	Person needs ALF level of care but cannot pay for this setting	Funding Openings for persons with MH needs
Timely access to:		
• Post-discharge supervision, such as In-home services, Mental Health Supports, Meds monitoring	Hospital knows that person needs more support post-discharge but person may not have Medicaid or access to CSB services	Consider using peer bridgers Use Mental health support services for persons with Medicaid
• ICTs or PACTs		Fund additional CSB ICT and PACT teams
• Meds at discharge	Persons may be eligible for Medicaid but haven't applied or have let it lapse	Review eligibility regularly Apply for SOAR
• Partial Hospitalization Program/Day programming	Persons may be ready for a lower level of care but need a step down to an intensive community option	Funding
Specialized services for persons with:		
• Violent behaviors		Funding
• Immigration issues	Persons may not be eligible for funding or CSB services	Establish residency if possible
• TBI	Minimal services available	Funding for community resources, including respite homes
• Dementia	Minimal services available	Additional funding for RAFT to serve those under age 65
• Developmental Disabilities/Asperger's	Staff are often unfamiliar with EBP for persons with DD	Funding; Training
• Homelessness	Persons may need funds for rent	Funding
• Veterans	Services from VA are hard to understand or access	Expand relationship with VA
• Sex offenses		Specialized programming
• Families	Persons need a support system upon discharge	Training and support for families Expand relationship with NAMI; MH of America

Education regarding:		
• NGRIs	NGRI may be hospitalized at private hospital but staff are not familiar with laws, procedures	DBHDS training
• Persons with ID	Staff are often unfamiliar with EBP for persons with ID	START will provide education
• Persons with dementia	ALFs and nursing homes may refuse to accept person with MH history	Funding for additional training for ALFs and nursing homes
• Medical clearance for state hospitals	Medical clearance may involve tests that seem unnecessary, can slow down a transfer to a state hospital	State Hospital training for Hospital Emergency Departments
• Cross-jurisdictional issues	Person may not get timely access to community services if he/she lives outside the jurisdiction of the hospital	Regular Coordination Meetings between CSBs and private hospitals re: specific persons
• Stigma reduction		
Non-placement Needs:		
• CSB resources for non-SMI persons		
• More CSB resources for ICTs, SA/MH residential treatment		
• Psychiatrists in private sector, especially with specialty areas for youth, geriatric, ID	Persons with insurance have difficulty finding psychiatrists	
• Guardianship		