

**GOAL II:** HPR V will develop a comprehensive system of care for individuals who have crisis and/or Regional Utilization Management Committee is currently reviewing the current levels of care continuum and has made numerous recommendations for change.

<b>Objective 2.1:</b> Create a continuum of care by expanding service options for clients with mental health, intellectual disability/development delay (ID/DD) and substance abuse who are in a state of crisis.	<b>Lead Committee:</b> Disability Chairs	Evaluation FY 2009	Date Completed or Recommended Timeline
<b>ACTION STEP</b>	<b>STAFF RESPONSIBLE</b>	<b>EVALUATION</b>	<b>END DATE</b>
<ol style="list-style-type: none"> <li>1. Review and document the system and levels of care within HPR V.</li> <li>2. Recommend additional services based on gaps and regional data.</li> <li>3. Review safety net protocols for individuals with mental health and intellectual disability/development delay (ID/DD) to ensure a viable option if required for long-term care.</li> <li>4. Develop protocols and resources for provision of mandatory outpatient services.</li> <li>5. Link crisis and acute service needs to the VACSB public policy initiatives for the upcoming General Assembly session.</li> <li>6. Link funding requests to the data and gaps in the system of care to foster further additional resource development and expansion.</li> </ol>		<ol style="list-style-type: none"> <li>a. Regional Utilization Management Committee is currently reviewing the current levels of care continuum and has made numerous recommendations for change.</li> <li>b. The Level of Care Matrix was used in the Regional Training in June 08, to address appropriate level on care at the point of intervention.</li> <li>c. Regional Utilization Management Committee uses data provided at each meeting to make recommendations around the use of per diem.</li> <li>d. Other recommendations include DAP operations and procedures, management medical clearance issues and ESH Bed management.</li> <li>e. We have met with forensic Coordinators and they have begun to evaluate current usage</li> </ol>	

		<p>and capacities related to ESH.</p> <p>f. Decided to move this to the end of document so that as our system is evaluated base on care needs recommendations for gaps in services delivery can be made to Executive team. (Since there will not be new funding, this items must continued for future funding).</p> <p>g. The RUMC has been working on the management of safety net options for MH/SA, and MH/MR. The groups is in the process of clarifying the crisis related needs of the project vs. the ongoing needs of the MR population, especially in light of the impending closure of SEVTC. Our goals will be to work with the MR Directors on the management of the safety net responsibilities for MR individuals.</p> <p>h. Also recommend that the MR staff, South Eastern Training Center, and DMHMRSAS become involved in providing the safety net responsibility. This may include the use of crisis ICF group homes as well as ALF as alternatives.</p> <p>i. Emergency Service Supervisors have met and</p>	
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		<p>develop a regional protocol for the management of Mandatory Outpatient Laws. Each CSB is currently in the hiring process and will be looking at specific protocols for their CSB.</p> <p>j. There is much concern about the change in the Law related to imminence: More work will need to be done around what will actually happen in the communities. Especially with special justice/magistrate training and the building of resource options in the community.</p> <p>k. The Chair of the Emergency Supervisors is in close contact with the state chair about regional issue related to emergencies. As these issues arise and need addressing information will be forward to the state chair so that VACSB public policy committee can address the issues.</p> <p>l. George Ennels has been elected as chair of the MH Council and will work closely with VACSB public policy committee to ensure information and recommendations from MH council are forwarded.</p>	
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**Team Members:** RUMC members

**Status:** Ongoing

**Overall Recommendations:**

- (1) Linkages with the HPR V Quality Managers should be implemented in FY 2010
- (2) Refine the criteria for the utilization of ESH as a level of care.
- (3) Refine the criteria for the utilization of non-inpatient alternative levels of care.
- (4) Continue movements towards the use of data to support the system of care.

**GOAL III: HPR V will support the goals and strategies of the Prevention Council**

<b>Prevention Program Goals, Objectives, and Strategies</b>				
<b>Goal 3.1:</b>	To develop prevention related legislative priorities			
<b>Objective:</b>	To incorporate prevention legislative priorities into the VACSB public policy agenda			
<b><u>Strategies/Activities</u></b>	<b>Projected</b>		<b><u>Responsible Staff</u></b>	<b><u>Expected Outcomes</u></b>
	<b>Start Date</b>	<b>End Date</b>		
1. Have representation on the VACSB public policy committee	7/1/08	On-going	Prevention Council Representative Joan Marsh	Interaction and feedback to and from the Prevention Council and VACSB
2. Maintain and expand partnerships with local prevention coalitions	7/1/08	On-going	Prevention Directors	Local prevention coalitions will support the VACSB Prevention Council's legislative priorities
3. Identify prevention legislative priorities	7/1/08	8/31/8	Legislative & Steering committees	Legislative priorities will be identified and submitted
4. Develop legislative plan	7/1/08	On-going	Legislative & Steering committees	Implementation of a prevention advocacy plan for the Commonwealth

**Prevention Program Goals, Objectives and Strategies**

<b>Goal 3.2:</b>	To increase and diversify sustainable funding			
<b>Objective:</b>	To identify non-traditional funding sources			
	<b>Projected</b>		<b><u>Responsible Staff</u></b>	<b><u>Expected Outcomes</u></b>
<b><u>Strategies/Activities</u></b>	<b>Start Date</b>	<b>End Date</b>		
1. Develop a clearinghouse of potential funding sources and update as new sources are identified	7/1/08	On-going	Funding committee members	List of potential funding sources
2. Research availability of new SPF/SIG grant opportunities	7/2/08	7/2/08	Freddie	Council will have knowledge about the availability of this resource. It is not available this year 7/2/08.

<b>Prevention Program Goals, Objectives and Strategies</b>				
<b>Goal 3.3:</b>	To demonstrate the value of prevention services			
<b>Objective:</b>	Document successful prevention products			
<u>Strategies/Activities</u>	<b>Projected</b>		<u>Responsible Staff</u>	<u>Expected Outcomes</u>
	<b>Start Date</b>	<b>End Date</b>		
1. Identify prevention's successful programs	7/1/08	On-going	Value/PR <u>Committee</u> Community <u>members</u> Prevention Council	1. VACSB, partner organizations and other entities will be better informed about the value of prevention services. 2. The VACSB annual report will accurately reflect prevention services data and showcase successful programs.
2. Increase visibility of prevention services	7/1/08	On-going	Value/PR Committee  Prevention Council	VACSB Conference materials will include prevention resources
3. Identify ways prevention programs impact treatment demands and outcomes	7/1/08	On-going	Value/PR Committee  Prevention Council	Research will be provided at VACSB conferences that identifies prevention research and facts and its relevancy
4. Showcase prevention outcomes at coalitions and board meetings	7/1/08	On-going	Value/PR Committee  Prevention Council	Display at all VACSB conferences that promotes prevention activities

<b>Prevention Program Goals, Objectives and Strategies</b>				
<b>Goal 3.4:</b>	To promote state-of-the-art professional development and best practices			
<b>Objective:</b>	By 2009, the Prevention Council will identify and implement core trainings for prevention personnel			
<u>Strategies/Activities</u>	<b>Projected</b>		<u>Responsible Staff</u>	<u>Expected Outcomes</u>
	<b>Start Date</b>	<b>End Date</b>		
1. Collaborate with DMHMRSAS Prevention State office on training needs of prevention staff	7/1/08	On-going	DMHMRSAS Prevention Training Committee	Develop "core" training recommendations for Prevention Directors and Specialists.  List sources of professional development
2. Collaborate with VACSB to provide training at conferences	7/1/08	On-going	VACSB Professional Dev. Representative  Prevention Steering Committee	Have appropriate prevention training at VACSB conferences
3. Collaborate with CBN and VTSF for training opportunities	7/1/08	On-going	DMHMRSAS Prevention Training Committee	Ability to provide a variety of prevention related trainings, workshops, etc.
4. Support DMHMRSAS implementation of an annual prevention conference	7/1/08	On-going	DMHMRSAS Prevention Training Committee	2-3 day Prevention conference

**Team Members:**

**Status:**

**Overall Recommendations**

**GOAL IV:** HPR V will develop a comprehensive system of care to support the transition of individuals who recently have used crisis and/or acute services.

<p><b>Objective 4.1</b> Create stronger partnerships With private hospitals in order To develop community Capacity.</p>	<p>Lead Committee: RAC/REDAC</p>	<p>Quarterly Update</p>	<p>Timeline</p>
<p><b>ACTION STEP</b></p>	<p><b>STAFF RESPONSIBLE</b></p>	<p><b>RECOMMENDED EVALUATION METHOD</b></p>	<p><b>END DATE:</b></p>
<p>1. Create a forum involving the private sector and public sector for the purpose of providing optimal or best practices that lead to recovery-oriented and least restrictive alternatives to state hospitalization.</p>		<p>a. The HPR V Regional Authorization Committee (RAC) has significantly evolved to function through its diverse membership of CSB ES Management, Case Management and Project Office UR staff as a conduit for policy recommendations enhancement, decision-making and information sharing focused upon insuring quality treatment outcomes in the acute and sub-acute care arena. Local private hospitals have direct access to the committee on a weekly basis to contribute to the ongoing quality improvement of the region's Acute Care project. The HPR V Reinvestment Project Director provides local private hospitals with higher-level opportunities for administrative input on Project operations that then serve to inform the RAC on matters pertinent to strengthening partnership with those providers and making the best use of capacity in the region.</p>	<p>Calendar Year 2009</p>

		b. Implement strategies to support clinical and administrative services.	
<b>Objective 4.2</b> Implement and evaluate The quality of care oversight for individuals transitioning in and out of the acute service arena.	Lead Committee: RAC/REDAC		
<b>ACTION STEP</b>	<b>STAFF RESPONSIBLE</b>	<b>RECOMMENDED EVALUATION METHOD</b>	<b>END DATE:</b>
2. Facilitate clinical case management review and make recommendations based on the reviews for clients who have utilized crisis stabilization and/or acute services within HPR V.		The HPR V Regional Authorization Committee provides several levels of quality assurance review for all admissions authorized in crisis stabilization and acute care services and the RAC Chairman reports outcomes/recommendations made to the Regional Utilization Management Committee and the Strategic Oversight Committee on a monthly basis.	
Link housing needs with legislative initiative and public policy directive via VACSB and grant opportunities.		Housing needs that comprise the majority of issues on the Extraordinary Barriers to Discharge List have been gathered to inform public policy initiatives.	Update this data 2009

**Team Members:** RAC/REDAC

**Status:**

**Overall Recommendations:**

Implement above mentioned goals in FY10

**GOAL V:**

Financial management incorporates plans for not only the short-term operational needs of the partners, but also the long-term solvency of the community-based system of care.

<b>ACTION STEP</b>	<b>STAFF RESPONSIBLE</b>	<b>RECOMMENDED EVALUATION METHOD</b>	<b>END DATE:</b>
	Lead Committee: Finance	Quarterly Update	Timeline
<p><b>OBJECTIVE 5.1:</b> Rebalancing of the ratios for Facility and Community Services funding to more equitable percentages (levels to be determined and phased in through enhancement of the regional "reinvestment" projects).</p> <p><b>OBJECTIVE 5.2</b> Infusion of additional State Resources for the under funded system of care (based on Virginia's national ranking.</p> <p><b>OBJECTIVE 5.3</b> Obtain full funding for a Regional Community Support Center (RCSC) at SEVTC.</p> <p><b>OBJECTIVE 5.4</b> Obtain funding for the Steppingstones Program at SEVTC to address individuals with co-occurring psychiatric disorders and challenging behaviors.</p> <p><b>OBJECTIVE 5.5</b> Obtain funding for the College of Direct Support as well as an ongoing training program on person-centered</p>			Continue with FY10 Plan

<p>planning, choice, self-determination and the role of staff as supporters and teachers of learning.</p> <p><b>OBJECTIVE 5.6</b> Obtain funding to allow for the sharing of SEVTC staff with community providers for the purpose of supporting and enhancing each individual's transition from the facility to the community.</p> <p><b>OBJECTIVE 5.7</b> Obtain funding streams to reimburse community residential providers when individual is "out of the placement" due to hospitalization (medical or psychiatric).</p> <p><b>OBJECTIVE 5.8</b> Obtain an increase in Family Support funds to fund emergent needs in the community thus decreasing the need for re-institutionalization.</p>			
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**Team Members:** Finance Committee under leadership to implement plan recommended by Regional Chairs. The original goals have merit; continued implementation in FY10 will require further discussion with Executive Directors.

**Status:**

**Overall Recommendations:**

**Attachment A: HPR V Forensic Planning Document**

**Pre-booking (first contact with police)**

<b>Problems</b>	<b>Suggested services/responses</b>	<b>Action Steps/Work Products</b>
Police are not trained to identify persons with MI or to know appropriate MH community resources to divert from arrest	<ul style="list-style-type: none"> <li>• Train Emergency services staff to triage with police and divert when appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Each CSB will survey their law enforcement to identify common problems with diversion.</li> <li>• Each CSB will develop diversion information (cheat sheet) for their law enforcement officers.</li> <li>• Each CSB will train their Emergency Services staff about diversion options with the police.</li> </ul>
	<ul style="list-style-type: none"> <li>• CIT programs are an effective MH/law enforcement diversion response; includes police training &amp; drop-off centers</li> </ul>	<ul style="list-style-type: none"> <li>• Each CSB will submit a plan that will provide CIT or CIT-like training for law enforcement officers each year.</li> <li>• Each CSB will facilitate discussion with law enforcement to explore drop-off opportunities in their communities.</li> </ul>

**Post-booking & jail MH services**

**(Waiting for bond, court dispositions, evaluations, treatment and sentence completion)**

<b>Problems</b>	<b>Suggested services/responses</b>	<b>Action Steps/Work Products</b>
Jail staff are not always trained to identify and treat persons with MI in jail	<ul style="list-style-type: none"> <li>• Train jail staff to identify symptoms of MI and the availability of expertise at the CSB; promote working agreements.</li> <li>• Jail-based MH services need to be maintained and expanded in most cases</li> </ul>	<ul style="list-style-type: none"> <li>• The region will develop a plan that provides organized training to staff of all jails in HPR V</li> <li>• Maintain existing jail-based MH services and expand where needed, including 1-2 "jail teams".</li> </ul>
The Jail staff often changes	<ul style="list-style-type: none"> <li>• The Community</li> </ul>	<ul style="list-style-type: none"> <li>• CSB will coordinate</li> </ul>

preferred/prescribed psychiatric medication due to differences in formularies between the hospital & jails.	Resource Pharmacy can be used for defendants in jail who were previously in the state hospital.	medication with the jail staff on behalf of former state hospital patients who return to jail
Judges and attorneys are not always aware of community-based evaluators or community-based and jail-based treatment services.	<ul style="list-style-type: none"> <li>• Training of judges and attorneys about MH resources and services; stakeholder planning groups.</li> <li>• When the defendant does not require hospitalization, forensic evaluation and restoration services can be provided in the jail or while on bond.</li> </ul>	<ul style="list-style-type: none"> <li>• Each CSB will arrange for at least 1 meeting with the area judges, CWA and public defenders each year. Efforts will be made to expand into private attorney opportunities.</li> <li>• Each CSB will have a designated person that will coordinate the provision of forensic evaluation services and restoration services for the courts, including screening the need for inpatient evaluation and restoration services.</li> </ul>
Hampton Roads Regional Jail (HRRJ) will not allow CSBs in their jail except for emergency services purposes or by court order	<ul style="list-style-type: none"> <li>• Request that “targeted” Executive Directors continue to meet with the Director of HRRJ with participation of DMHMRSAS</li> </ul>	<ul style="list-style-type: none"> <li>• Develop cooperative agreements with HRRJ to specify the CSB services</li> <li>• Identify other alternatives to HRRJ???</li> </ul>

**In-Patient forensic services at ESH and CSH  
(Entry to state facility)**

<b>Problems</b>	<b>Suggested services/responses</b>	<b>Action Steps/Work Products</b>
Long waiting lists for forensic admissions delay needed inpatient services and the justice process for the defendant	<ul style="list-style-type: none"> <li>• Active contact by ESH and CSH with the CSB to screen/triage the defendant waiting in jail; coordination with jail medical services or provision of CSB jail-based MH services when available.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals will distribute waiting list information immediately to CSB</li> <li>• CSB will designate 1 person to be contact person for Hospitals.</li> <li>• Hospitals will maintain regular contact with CSB person to assess MH status of waiting defendant.</li> </ul>
	<ul style="list-style-type: none"> <li>• Active contact by ESH and CSH with the jail to monitor the MH status of the defendant in jail.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals will establish and maintain contact with Jail Medical staff about the defendant</li> </ul>

	<ul style="list-style-type: none"> <li>• Contact by ESH and CSH with court to apprise them of defendant's status/need for inpatient services.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals will establish contact with courts to inform them of the waiting list situation and recommendations of the CSB and Jail Medical staff regarding need for inpatient services.</li> </ul>
	<ul style="list-style-type: none"> <li>• Moving NGRI patients into the community as approved by the court is critical to available bed space at ESH and CSH</li> </ul>	<ul style="list-style-type: none"> <li>• Maximize community visit opportunities for NGRI patients with unescorted community privileges</li> <li>• Solicit providers that will work with NGRI patients in the community</li> <li>• Maximize available funding opportunities, e.g., DAP funding and transformation services</li> <li>• John Favret stated that ESH is open to the concept of the region exploring ESH housing stock for region-run housing for appropriate patients who are discharged from ESH.</li> </ul>
Forensic patients that change to "civil" status remain in forensic beds at ESH and CSH		
Future forensic inpatient capacity at ESH will be reduced		

**Planning for Re-entry  
(Re-entry to community)**

<b>Problems</b>	<b>Suggested services/responses</b>	<b>Action Steps/Work Products</b>
Lack of discharge planning from the hospital back to the jail	<ul style="list-style-type: none"> <li>• Active discharge planning between ESH and CSH with the CSB for the defendant returning to jail and follow-up services while in the jail is needed.</li> </ul>	<ul style="list-style-type: none"> <li>• ESH and CSH staff will fully acquaint themselves with the MH services available in each jail.</li> <li>• ESH and CSH will coordinate discharge planning with the appropriate CSB.</li> </ul>

		<ul style="list-style-type: none"> <li>• CSB will implement discharge plan in the jail (and after discharge from the jail).</li> </ul>
	<ul style="list-style-type: none"> <li>• Sometimes charges (and the forensic status) are dropped, allowing patients to be directly discharged from the hospital (vs. returning to jail).</li> </ul>	<ul style="list-style-type: none"> <li>• John Favret stated that ESH is open to the concept of the region exploring ESH housing stock for region-run housing for appropriate patients who are discharged from ESH. Hopefully, HPR V patients at CSH would be added to this group.</li> </ul>
<p>Lack of discharge planning is rare <u>from the jail back to the community</u>. Discharge planning void can create recidivism.</p>	<ul style="list-style-type: none"> <li>• Active discharge planning for defendants returning to the community from the jail is needed. Additional challenges include entitlement disruption and the lack of community resources. Front and backend planning and resources are critical to the success of working with forensic patients.</li> </ul>	<ul style="list-style-type: none"> <li>• Jail MH will arrange an initial appointment with the CSB for each inmate leaving jail w/ serious mental illness.</li> <li>• Jail MH will coordinate discharge info with CSB staff for each defendant on psychotropic meds.</li> <li>• CSB will provide a single point of contact to Jail MH staff and defendants in the jail.</li> </ul>

#### Other concerns/realities

Problems	Suggested services/responses	Action Steps/Work Products
CSBs are not "incentivized" to work with defendants in the jail	<ul style="list-style-type: none"> <li>• Explore all available resources – local, regional, state and federal</li> </ul>	<ul style="list-style-type: none"> <li>• Apply for funding opportunities</li> </ul>

## **HPR V FORENSIC SERVICES VALUES**

Incarcerated person should have access to MH services as quickly as possible and in the least restrictive environment as possible. Inpatient MH services is the most restrictive setting for services and should be sought only when absolutely necessary.

Persons with mental illness should not get caught up in the criminal justice system needlessly when community-based services are available.

Persons with mental illness should not spend more time in jail because they cannot access appropriate MH services to proceed in the system, e.g., forensic evaluations and restoration services.

Current CSB clients who become incarcerated should have the benefit of CSB involvement in their care for good practice and continuity of care.

Incarcerated defendants will come out of jail/prison. It is good practice to provide case management and discharge planning while they are incarcerated to maximize good outcomes and minimize recidivism.

MH status should be maintained or improved while incarcerated.

Forensic clients will have the same access to Reinvestment and Transformation resources as civil clients have.

Explore and make use of all resources to bring services to bear for forensic services (includes private inpatient services)

**Attachment B: Geriatric Psychiatry Strategic Plan**  
Not included

**Attachment C: Intellectual Disability/Developmental Delays Strategic Plan**  
Not included

**Attachment D: Consumer Advisory By-laws**  
Not included