SB176/HB888 Workgroup on Placements in Virginia for People with Neurocognitive Disorders and Neurodevelopmental Disabilities

Secretary of Health and Human Resources

Friday, September 13, 2024 | 1:00 p.m. – 3:30 p.m.

Location: DARS with Virtual Option

MINUTES – Meeting Four

In-Person	
Leah Mills, HHR Deputy Secretary	Jason Young, VABIAV
Braden Curtis, DBHDS	Glynis Boyd Hughes, (Proxy for Judy Hackler) VALA
Heather Norton, DBHDS	Dana Schrad, VA Chiefs of Police
Aimee Perron Seibert, VCEP	Nicole Durose, dLCV
Trevor Moncure, PSV	Teri Morgan, VBPD
Brian Kelmar, Family Advocate	Christine Schein, VHHA
Jennifer Faison, VACSB	Catherine Harrison, DARS
Karin Addison, Neuro Restorative, Brain Injury Facility	Lisa Jobe- Shields, DMAS
Jason Perkins, DMAS	Curt Gleeson, DBHDS
Joshua Myers, Alzheimer's Association of Virginia	Lucy Cantrell, Arc of VA
Online	
Delegate Vivian Watts	Tammy Whitlock, DMAS
Steve Ford, VHCA /VCAL	Theresa Champion, VA Autism Project
Martin Mash, VOCAL	Bruce Cruzer, MHV
Elizabeth Hobbs, VA Sheriffs Association	Kathy Stumm, Family Advocate
Dana Parsons, Leading Age	Lauren Webb, VACEP
Tonya Milling, ARC of VA	Jonathan Green, OES VA Supreme Court
Byron Wine, The Faison Center	Nathalie Molliet-Ribet, BHC
HF, Family Advocate	Jonathan Gray, Family Advocate

Welcome - HHR Deputy Secretary Leah Mills

Deputy Secretary Mills welcomed and thanked all of the participating workgroup members and members of the public. She reviewed major take aways from the last meeting and key themes discussed to guide recommendations. Deputy Secretary Mills emphasized the importance of continuing to keep the needs identified by individuals with lived experience and their supporters at the center of all decisionmaking.

Public Comment

No one signed up to provide Public Comment

Stakeholder Perspectives

Families introduced by The Arc of Virginia:

Jonathan Gray shared his family's experiences supporting his adult son who has Autism and Bipolar disorder and is non-verbal with high support needs. Mr. Gray's son received care in state hospitals after being denied admission to private facilities. Mr. Gray shared concerns about the use of restraints during these episodes of care. After receiving care out of state, Mr. Gray's son returned to Virginia and received care in adolescent group homes. Mr. Gray's son was placed under another TDO as an adult and sent to another state psychiatric facility for treatment. While receiving treatment he lost his placement at his group home. His discharge was delayed by the need to find an appropriate placement that would accept him. Mr. Gray recommended the workgroup address the need for more care options for people like his son.

HF shared their family's experience supporting an adult with multiple co-occurring disabilities including developmental disability. They have experienced multiple hospitalizations and periods of homelessness. HF noted that the application process for the developmental disabilities waiver is confusing for families to navigate. HF shared that their family was uncomfortable during the application process having to discuss all support needs and behavioral challenges with the individual present and feared that it may negatively impact their mental health.

Family of individual with Traumatic Brain Injury:

Kathy Stumm shared her lived experience supporting her adult brother with traumatic brain injury. Her brother had positive experiences receiving care in assisted living facilities (ALFs). Ms. Stumm shared that her brother had been deemed eligible for a Medicaid waiver but declined because accepting it would have required him to move from his ALF to a group home or skilled nursing facility. His residence at an ALF also limited access to other Medicaid covered services. Ms. Stumm noted 38 states allow ALFs to participate in Home and Community Based Services (HCBS) under Medicaid. She acknowledged that ALFs would have to meet higher requirements but felt that this would be possible for some providers, and she recommended DBHDS and DMAS take steps necessary to expand access to ALFs.

Families introduced by Theresa Champion with the Virginia Autism Project:

Ms. Champion provided an introductory presentation to the workgroup. She reviewed core features of Autism Spectrum Disorder (ASD) and DSM-5 levels of severity noting that people with ASD also may have other co-occurring disorders. Ms. Champion noted that ASD is frequently misdiagnosed as mental illness and emphasized the need to identify and provide appropriate supports to people with ASD. She shared common problems encountered by families and individuals with ASD engaging with law enforcement. She concluded by sharing recommendations on behalf of the Virginia Autism Project emphasizing that there is a need for appropriate placements for individuals experiencing a crisis when it is a manifestation of their ASD to receive treatment outside of mental health hospitals.

Sylvia Orli shared a presentation on her family's experience supporting her son through crisis in June 2024 in Arlington, Virginia. Ms. Orli's son has autism and is non-speaking. Ms. Orli said that the family called 911 and REACH. Twelve police officers responded to the 911 call. The family was told that there was a CIT trained officer present but it was unclear which officer it was. Ms. Orli said that REACH did not respond citing police presence, and the crisis center would not accept him due to his Autism. Ms. Orli said that de-escalation was not attempted, and her son was handcuffed and taken to the ER where he was handcuffed to a bed. Ms. Orli's son received sedation in the ER over his objection. Ms. Orli said that her son returned to his normal behavior but continued to be heavily sedated and restrained. He was placed under a TDO while in the ER and his family was not permitted to take him home. Ms. Orli said that the family was not consulted during the decision-making process to place him under a TDO. Her son was allowed to go home after several hours on an IV to treat conditions like severe dehydration he developed there. Ms. Orli presented an alternative narrative of what should have happened. She suggested that one CIT trained officer and one REACH counselor should have to de-escalate and assess. If her son had to be taken from the home he should have been brought to a facility specializing in mental health crisis stabilization for people with neurodevelopmental disabilities, like a crisis center or a psychiatric ER, but must include trained individuals who understand his special needs and can help him without the use of handcuffs or sedation. Ms. Orli said her son should have been released from his ECO and moved from the ER to a quiet room for him to recuperate and staff to assess his crisis level without sedation. Once it was clear that there were no psychiatric placements available and her son was no longer in crisis, his parents should have been permitted to take him home to receive in-home supports.

Peter Francisco shared his experience supporting his adult son with multiple disabilities including Autism and visual impairment through crisis. Three years ago, his son had a crisis consistent with his Autism diagnosis. Mr. Francisco called 911 and requested a CIT trained officer to respond, but the officers who arrived were not CIT trained. Multiple units responded, and his son was handcuffed without de-escalation attempted. Mr. Francisco said that his son deescalated before he was taken from the home, but officers told the parents that he had to either be transported to the ER or he would be arrested for assaulting a law enforcement officer. Mr. Francisco's son was taken to the ER and then placed at a state facility. Mr. Francisco said that his son acquired new challenging behaviors during his time at the facility. When he returned home, he was charged with felony assault of a law enforcement officer. The family hired an attorney

who was successful in getting the charge dropped. Mr. Francisco said other families may not have this experience.

Virginia Crisis Connect, Marcus Alert, and the Current Status of the Crisis Services Build-Out - Curt Gleeson and Emilee Grossi, DBHDS

Curt Gleeson provided the workgroup with an overview of the Virginia Crisis Connect (VCC) system. Based on the SAMSHA Crisis Now Model, the VCC system includes Crisis Call Centers, Mobile Crisis, and Crisis Stabilization Sites. Mr. Gleeson noted that REACH is being integrated within the VCC system. He showed stakeholders how they can receive updated information on the status of the build-out on the DBHDS Public Dashboard. Emilee Grossi reviewed the Marcus Alert dispatch levels and triage framework and explained how they support 988 and 911 integration in the areas where Marcus Alert has been implemented. Mr. Gleeson discussed how VCC provides the technological framework for the system coordinating 988 call center operations (launched in January 2022), mobile crisis response (full implementation completed in December 2023), and facility referrals (full implementation projected for January 2025). Mr. Gleeson and Ms. Grossi reviewed how VCC and Marcus Alert operate within Intercept 0 of the Sequential Intercept Model to divert individuals from involvement in the criminal justice system.

Workgroup Discussion:

Members asked if data was tracked on the number of people engaging in mobile crisis who have Autism and if mobile response teams are trained to respond to people with Autism. DBHDS staff responded that REACH is integrated with 988 and data is tracked and reported for that program. Developmental disability diagnosis is included in a data template for Marcus Alert going through the process of being approved for implementation. DBHDS does not currently receive this information from private mobile crisis providers who are dispatched through the 988 platform.

DBHDS staff noted that the state is using a data-informed approach to building out the VCC system, accounting for population, TDO rates, etc. The workgroup discussed whether the current REACH infrastructure was adequate to support needs in the state.

Workgroup members asked if individuals can be tracked over time through the VCC system to identify frequent utilizers of crisis services. DBHDS staff noted that the capability exists to view certain case records; however, information sharing across entities is restricted as required by state and federal privacy protections.

Workgroup members suggested building out a mechanism for individuals receiving crisis services and their supporters to submit feedback on the services they received.

Reimbursement and Brain Injury Services - Lisa Jobe-Shields and Jason Perkins, DMAS

Ms. Jobe-Shields and Mr. Perkins provided an overview of services covered under current Virginia Medicaid 1915(c) Waivers, which include the Developmental Disability (DD) Waivers

and the Commonwealth Coordinated Care Plus (CCC+) Waiver. They highlighted the crisis supports covered under the DD waivers and noted that the CCC+ waiver does not include skill-building and rehabilitative support services. They emphasized that access to a wide array of services is essential to individuals maintaining stability in the least restrictive setting and preventing crisis. They reviewed the requirements of the federal Home and Community Based Settings (HCBS) Rule. They reviewed the current continuum of Mental Health Services under the State Plan noting the new services added to the state plan under Project BRAVO in 2021 and additional changes anticipated under the current Medicaid Behavioral Health Redesign project. They noted that currently there are no residential behavioral health treatment services covered on the state plan for adults, only for youth. They noted that DMAS currently has an 1115 waiver for Substance Use Disorder (SUD) services (ARTS) and a former foster care youth program. DMAS is required to report to the General Assembly annually on plans to develop a parallel waiver for mental health services. They concluded by reviewing the proposed service continuum for Brain Injury. The proposed continuum includes Home and Community Based Services under a 1915(c) waiver and neurobehavioral treatment unit coverage under the state plan for individuals with Brain Injury or neurocognitive disorder, as well as Targeted Case Management coverage under the state plan for individuals with Traumatic Brain Injury (TBI). DMAS was authorized and funded to move forward with the implementation of targeted case management services for individuals with TBI.

NeuroRestorative's Virginia Programs - Victoria Harding

Dr. Victoria Harding presented to the workgroup on the two programs currently operated by NeruoRestorative in Blacksburg, Virginia. These programs operate on a 24/7 care model that could be replicated and expanded to meet more needs/serve people in the community outside of the institutional setting. These are currently the only programs of their kind serving individuals with brain injury in a community setting in the state to operate with public funding. Funding sources include VA contracts, Discharge Assistance Planning (DAP) funds, workers compensation as well as other states' public funding and commercial payors. Dr. Harding highlighted how states can leverage federal funding through Medicaid Home and Community Based Waivers to support individuals with Brain Injury. She noted there have been over a dozen studies in Virginia evaluating available brain injury resources and gaps in services for individuals with traumatic brain injury and dementia, with all consistently concluding that the needs of individuals and their caretakers are not being met. She referenced acts of the General Assembly in 2022 to require DMAS to establish a Targeted Case Management Service for individuals with severe Traumatic Brain Injury and to convene a workgroup to develop a plan for a neurobehavioral science unit and a waiver program for individuals with brain injury and neurocognitive disorders. She noted that HB1064 was introduced during the 2024 General Assembly Session to create a Brain Injury unit with capacity to treat 575 individuals annually and a fiscal impact of $10 million. Dr. Harding concluded by emphasizing that a Specialized Neurobehavioral Unit is different from institutional or Nursing Facility settings as they are staffed by Brain Injury Specialists and outcomes-oriented with a focus on increasing independence to support discharge. These units provide highly skilled specialized services for people with challenging behavior and keeps them out of emergency departments, psychiatric hospitals, and the criminal justice system.

Adjourn

Deputy Secretary Mills provided closing remarks and shared tentative dates for the next meeting.