

STATE OF WEST VIRGINIA  
THIRTEENTH JUDICIAL CIRCUIT  
OFFICE OF THE COURT MONITOR  
STATE CAPITOL COMPLEX  
BUILDING 6, ROOM 850  
CHARLESTON, WEST VIRGINIA 25305



LOUIS H. BLOOM  
JUDGE

DAVID G. SUDBECK  
COURT MONITOR

## MEETING OF THE PARTIES

*In E.H., et al., v. Khan Matin, et al.*

MONDAY, APRIL 9, 2012

### MINUTES

**PRESENT:** Kevin Stalnaker, Vickie Jones, Cindy Beane, Dee Weston, Dan Hedges, Wendy Elswick, Regenia Mayne, Teresa Brown, Ken Devlin, David G. Sudbeck, Sheila Kelly, dan connery

#### I. COURT MONITOR REPORT

David Sudbeck followed up on several issues from the previous Meeting of the Parties.

Wendy Elswick confirmed that a draft amendment regarding Item 3f (Crisis Stabilization services) of the Agreed Order has been developed and circulated. The amendment was approved and signed by Petitioner during the Meeting of the Parties by Dan Hedges.

In addition, a memorandum regarding rates for use of the Crisis Stabilization Units for commitment and step down from hospitalization was circulated to providers as requested by the Parties. Kevin Stalnaker interjected that though the rates exist, very few providers are using them for either purpose. Vickie believes that in part, this is due to concerns by providers regarding the dangers or difficulties of mixing the two populations.

Sheila Kelly stated that there was general agreement in the group developing revised behavioral health rules that the new rule should enable locked-door facilities in some circumstances. The group believes that locking doors is a safer alternative for consumers, staff and communities than delayed doors in some programs. Dan asked that he be included on copies of the consumer rights amendments that were being added to Chapter 27 in place of 64CSR74. The group working on this language has been heavily represented by advocates including WVA and the Consumer's Association. Sheila will forward the working draft to Dan for comment.

David also inquired of Vicki Jones whether the draft document regarding Gatekeeping that the BHHF had circulated among the Parties had received any comments. She stated that she had

received no comments. Dan suggested an addition to the document requiring that the Department circulate quarterly commitment figures by CMHC area, preferably expressed as a ratio of commitment to population to allow comparability. Sheila pointed out that areas that had “magnet” psychiatric units would have high rates of commitment of consumers from other counties, however the BHHF indicates that they have no other valid method of counting. The BHHF agreed to provide that information quarterly (the data is already collected and will be collated quarterly and circulated).

## **II. BHHF REPORT**

Vickie Jones informed the Parties that Senate Bill 437, the Governor’s Substance Abuse bill, has passed, and that The Governor’s Advisory Council on Substance Abuse meeting would occur on April 11, 2012 to recommend to Governor Tomblin how the obtained funding should be earmarked for substance abuse services. This meeting is the culmination of months of regional meetings during which suggestions regarding community needs for substance abuse prevention, intervention, treatment and recovery were submitted to the coordinating committee that will make recommendations to the Governor for distribution of 7.5 million dollars in funding (5 million for on-going use and 2.5 million for one time expenditure). She also demonstrated the data and mapping capabilities that the Department had generated, displaying for each area of the state the services available. This will enable the Department to do an analysis and identification of regions where there are gaps in any of the six areas. A directory of substance abuse services will also be released to aid in the provision of services to individuals in certain geographic areas.

## **III. PETITIONER REPORT**

Dan Hedges presented two Requests for Resolution: one regarding Patient Advocacy and Appeals and the other, Discharge Planning. Plaintiffs argue in the former that Respondent was not allowing patient advocates to investigate freely, nor is the Department providing sufficient internal investigation and objectivity to patient appeals. Vicki Jones explained that BHHF has a policy with regard to patient appeals that has been in place for many years. This procedure requires that all appeals be reviewed by the Deputy Commissioner (formerly the Director of OBHS). This procedure is being followed however an additional step has been added in that prior to final decisions being rendered, the Deputy Commissioner passes the appeal for investigation to the BHHF Office of Compliance which has been charged with investigation of patient appeals. There is a newly created Office of Consumer Affairs as well as a newly created Office of Compliance, which is assigned overview responsibility for these issues due to the abilities of the staff to perform this function.

Wendy Elswick also clarified that at this time both audio and video recording of conversations/interviews with patients and staff are allowed, and that Respondent will provide and has been providing this documentation in a timely manner to advocates. The Bureau could recall only one occasion in which video evidence was delayed by the vacation of the staff person in charge of releasing the information. She stated however that the Bureau was seriously considering not permitting tape recording of interviews due to the fact that Adult Protective Services policy forbids such taping. Allowing advocates to continue to tape would create a situation in which two separate investigations had to be held (one by APS and one by advocates) when the investigations have been done jointly in the past.

#### **IV. BMS REPORT**

Cindy Beane stated the TBI Waiver Policy and Procedure is in place and that Susan Given has been hired as the TBI Waiver Program Manager. She also informed the Parties that outreach efforts are in place and that at this time five licensed behavioral health centers, fifteen case management agencies, and fourteen personal attendant agencies have been enrolled as TBI waiver providers, and BMS has provider coverage to serve forty counties. Three individuals have been determined medically eligible for participation in the program to date, two from a nursing home and one from Radical Rehabilitation. Two of the patients will be returning from out of state placement.

Regenia asked that at the next meeting, the Bureau discuss the proposed Medicaid Emergency Psychiatric Aid grant submitted to CMS. This grant is designed to allow BMS to reimburse private Institutions for Mental Disease (IMDs) in West Virginia for inpatient psychiatric acute care. This grant allows BMS to reimburse Highland Hospital and Riverpark Hospital for inpatient acute care. Cindy agreed to present on the proposed grant at the next meeting.

#### **V. SPECIAL ASSISTANT REPORT**

Sheila presented a report (attached) that she had completed only this week on discharge planning in the diversion facilities. This report was done coincidental to the RFR by Petitioners. In general she was pleased with the quality of discharge planning being done in most facilities but had some concerns about DHHR use of Health Care Surrogacy (HCS) for individuals who, in reality, needed guardians. WVA expressed concerns that some DHHR workers were not following policy as outlined by DHHR and for that reason, relatives who could have served as HCS were being overlooked. Petitioners agreed that the Department may reference the report in their response to the Petitioners Requests for Resolution on Discharge Planning. Dan agreed that the fourth item on the RFR regarding "Long Term or difficult to place patients" referred to patients in the two state facilities. He agreed with Sheila that it was reasonable to ask the advocates of the two facilities to identify a list of those patients for her to use in investigating the complaints.

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Next Meeting: Monday, June 4, 2012  
10:30 a.m.-12:00 noon  
Covenant House  
600 Shrewsbury Street, Charleston, WV 25301

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TO: E.H., et al, vs Khan Matin, et al, Parties

FROM: Sheila Kelly, Special Assistant  
Office of the Hartley Court Monitor

RE: Informal report regarding discharge  
Planning in the Diversion hospitals

DATE: April 2, 2012

As an aspect of the review of progress toward compliance with the Agreed Order, the Special Assistant volunteered to conduct a series of visits to the more heavily utilized private diversion hospitals to evaluate the discharge planning processes and to see how many were familiar with the Prescription Practices and physician handoff protocol developed by DHHR in response to the requirements of the order at Item 4. (8).

During the past two months the following hospitals were visited: River Park, St. Mary's, Fairmont General, Ohio Valley Medical Center, Highland Hospital, the Behavioral Health Pavilion in Bluefield and Appalachian Regional Hospital in Beckley. These are the most intensively utilized diversion facilities in the system. Camden Clark in Parkersburg is also used regularly but during the two month period averaged only 2 patients on diversion. Generally, although Camden Clark has specific complaints about Westbrook Health Center's CRU, in particular, the relationship between the two facilities is open and communicative. Camden Clark has very few patients that are not local (or from across the river in Ohio) and therefore has no problems with discharge planning since the hospital deals primarily with Westbrook.

The following conclusions/opinions are offered:

1. As I have said repeatedly, very few patients are being admitted who do not need to be admitted, although some could have been admitted without being committed. However, with

few exceptions, ALL patients are certified by a practitioner provided by the community mental health center (CMHC) in the area from which the patient is being committed. The exceptions are the catchment area of Potomac Highlands Guild (I don't believe this Center even has a certifier on staff and emergency room doctors from Grant Memorial do the commitments under an arrangement with the Center) and Logan Mingo MHC (Logan Mingo usually provides a crisis worker to the emergency room at Logan Area Medical Center when necessary but the emergency room physicians do the certifications after hours).

2. For the most part, the majority of patients are discharged within 12 days. For those who are exceptions, there are three reasons: placement (lack of), inability of the hospital to stabilize the patient psychiatrically, and/or in rare occasions, the tendency for patients to demonstrate an acceleration of psychopathology when presented with discharge options, making it impossible for the hospital to safely discharge the patient.
3. In facilities in which the majority of patients are from within the local CMHC's catchment area, discharge planners are responsive, available and well known to hospital staff. For example, BARH is very pleased with its current relationship with FMRS and River Park works closely with the Prester Center in Huntington.
4. The further the CMHC is from the diversion facility, the more likely it is that there will be problems in communication between agencies. The more agencies with which the hospital must deal, the more likely it is that there will be problems. For example, Fairmont General accepts patients from many counties and several CMHCs do not participate in discharge planning.
5. Most hospitals were either familiar with the protocols (St. Mary's referred to them as their discharge planning Bible) or felt that their discharge summaries and processes were compliant with the protocol. Pat Ryan of Fairmont General and Karen Yost of River Park participated in the development of the policies and are certainly familiar with them. Staff from Highland and BARH had never seen the protocols (I imagine they were sent to chief administrators and never shared). BARH has no complaints about FMRS and discharge planning. Highland has no complaints about Prester's participation but other CMHC patients do not always receive full participation from discharge planners.
6. Lack of participation in discharge planning by DHHR guardians and Health Care Surrogates (HCS) is an enormous problem for most hospitals. More appropriately stated, DHHR guardians and HCS is not actively involved, in most cases, in finding placements for protected adults who are languishing in facilities for lack of placements. Patients are placed on a "state wide list" for

placement but often that is the extent of guardian/HCS participation. DHHR has taken the position that guardians and HCS are not responsible for finding/arranging placements for protected adults, leaving all placement-finding arrangements to hospital social workers. Because guardians cannot approve placement in unlicensed facilities, placement in facilities in Virginia or Ohio is often available but forbidden by DHHR. There are additional problems with out of state placements in that other states may not accept WV guardianship as authority for placement and the facility may not have a Medicaid contract for payment with West Virginia. All of these result in reluctance on the part of DHHR guardians to consider out of state placement, even when in state options have been exhausted.

7. Many protected adults need placement in twenty four hour supervised living programs. Even state operated nursing homes have refused to accept patients with a history of sexual acting out or aggression (to be fair, these facilities accept many more behavioral health patients than will private facilities) and placement in Assisted Living Facilities (ALF) is often unsuccessful for behavioral health patients. Placement of these patients takes months. Hospitals sometimes have difficulty justifying to insurers the level of care the patient is receiving in an acute inpatient unit once the patient has stabilized and is awaiting placement.
8. DHHR has taken to using the HCS process in place of guardianship, sometimes inappropriately. HCS may not approve placements in any facility other than a medical/health facility according to the DHHR Health Care Surrogacy manual. (This policy statement is often ignored by DHHR HCS, who are authorizing placements inappropriately and outside their legal authority). If the policy is appropriately followed, an incompetent or persistently impaired individual sits in limbo when the placement that can be arranged for them is not an ICF ID or a nursing home (for example, an HCS may not approve placement in an adult family care home or a personal care home/ALF). Additionally, HCS may not assist in applying for benefits such as social security disability on behalf of the patient, whereas a guardian may.
9. In cases in which hospitals have good relationships with experienced CMHC linkage workers and care coordinators, discharge planning goes more smoothly and the CMHC serves as a resource for hospital social workers. This is particularly true if the CMHC mid level management meets regularly with hospital social workers and supervisors to iron out mutual problems.
10. CMHCs are supposed to provide an appointment for outpatient followup for discharged patients within a short period of time after discharge. While appointments are often (although not always) given, there are several problems: Most importantly, while there can be an appointment

for intake made, many Centers cannot provide appointments for medication management, sometimes for over a month. Patients often are forced to stop taking medications because the hospital cannot supply them for the extended period of time required to make it to the CMHC appointment, which leaves the patient in “limbo”, without medications. Those that are uninsured have more difficult problems in that they cannot afford to fill the prescriptions given them on discharge. Secondly, patients are often told to “walk in on clinic day” to see the physician for followup. Transportation is historically a problem and some centers do not use care coordinators to supply this service. Once a patient misses an appointment or two for med checks, they are often discharged or forbidden to make appointments with physicians. While this is understandable, it does not assist a patient already resistant to medication compliance.

#### Suggestions

1. Patients should be diverted to the hospital closest to their “home” CMHC unless they are receiving private practice services only, so that linkage can be face to face whenever possible.
2. Contiguous CMHC mid level staff and hospital social work staff and supervisors should meet on a quarterly basis to iron out issues.
3. CMHCs should be tracking individuals committed from their geographic region and participating in discharge planning with hospital social workers to the maximum extent possible (this is occurring in many areas). This would entail the notification of CMHCs when individuals are committed from other regions (e.g., a Webster County patient is committed from a BARH emergency room).
4. DHHR needs to revisit Health Care Surrogacy policy to discuss placement authorizations in non-medical settings (who can authorize? What is the process? Who is responsible?) As I have suggested before, Health Care Surrogacy and Guardianship are full time professions that should not be mixed with Adult Protective Service investigations.
5. Care coordinators and ACT team members should be providing transportation to medication management appointments. Medication management appointments need to be available before the individual runs out of medications supplied by diversion facilities.

#### Conclusions

In areas in which CMHCs are adjacent to diversion facilities, discharge planning seems to be done more smoothly and successfully. In general, coordination between diversion hospitals and CMHCs

seems to be occurring for most patients, with pockets of excellence occasionally offset by cases in which discharge planning does not go smoothly. Most Centers have developed good working relationships with hospital social workers. The most significant problem I encountered between CMHCs and diversion hospitals is the lack of access to community based medication management that is timely.

A much more significant problem is placement: options are scarce for supervised placement, and DHHR guardians or HCS are often not helpful and on occasion, counter-productive. Nursing home placement for mental health patients meeting nursing home admission criteria is very problematic.