

STATE OF WEST VIRGINIA
THIRTEENTH JUDICIAL CIRCUIT
OFFICE OF THE COURT MONITOR



Report to the
Court and Parties

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

October 10, 2012

■ INTRODUCTION ■

As required by an order of the Thirteenth Circuit Court in the matter of E.H. et al v Khan Matin, et al, the Court Monitor is to regularly submit a report to the Court and the Parties with regard to measures agreed by the Parties and/or ordered by the Court. **This shall serve as the Court Monitor's fourth regular report since his appointment in July, 2009.**

The report will describe and comment upon the progress made by the Parties with regard to implementation of the court orders on "**Case Management**" (August 7, 2009), "**Traumatic Brain Injury**" (August 7, 2009), and the "**Agreed Order**" (July 2, 2009). A section of the report will also concentrate on the activities of the Special Assistant as they relate to tracking and monitoring individuals committed to either public or private hospitals.

■ OVERBEDDING ■

The Office of the Court Monitor has been carefully observing the daily census at both state hospitals and in the diversion facilities used by the Bureau for Behavioral Health and Health Facilities (BHBF) over the year since the Office's last annual report. For the most part, populations in the state facilities have hovered at or near licensed capacity with occasional bursts of excess census due to unusual circumstances in the community or due to what appear to be seasonal fluctuations in commitment rates that seem somewhat predictable but are nonetheless mysterious. Both hospitals have now experienced several weeks of populations below licensed capacity.

Some issues affecting capacity, regardless of actual census, are as follows:

- The increasingly severe nature of the mental illness or behavioral problems of the state hospital population has served to increase the number of patients requiring one to one staff assignment on a twenty four hour basis. Even though units may be adequately staffed, one to one assignments diminish the staff available to deal with day to day tasks. At one point of which this office was aware, Bateman Hospital had eleven patients assigned one to one staffing.
- Termination of one of two psychiatric units at St. Mary's Hospital resulted in the overall loss of 15 inpatient psychiatric beds in the Bateman catchment area. This caused some problems in census through late Spring and Summer in 2012.
- The opening of the new Highland Hospital facility in Charleston resulted in more adult psychiatric beds being made available for diversion, and subsequently served to reduce the census at Bateman from several beds above licensed capacity to less than 100 (in a licensed capacity of 110) during the early weeks of August.

The Office will continue to monitor and work with BHBF to ensure that populations in the state psychiatric facilities remain at a level that is safe for staff and patients. (See enclosed Average Monthly Census of State Psychiatric Facilities.)

■ FACILITATION OF REWRITE OF CHAPTER 27 AND OF 64CSR11 ■

In early 2011, Secretary Lewis requested the services of the Special Assistant to facilitate a rewrite of the Behavioral Health Center regulations, utilizing a broad, transparent, participative model of involvement of all stakeholders. The Special Assistant coordinated and staffed this activity and the revised rule was completed, with apparent consensus among all stakeholder participants, well in advance of the July, 2012, timetable. However, it was decided that the new regulations would require considerable renovation of Chapter 27, the statutory enabling language for behavioral health and state-operated health facilities in West Virginia. The goal was to have those revisions completed in time for the 2013 Legislature to approve the statutory changes and approve the completely rewritten behavioral health services and supports regulations as an emergency rule. For that reason a committee was organized and implemented, facilitated by the Special Assistant and legal staff from the Secretary's Office. Unfortunately, changes in the structure of the Secretary's Office have temporarily placed the project on hiatus, making it unlikely to be ready for the 2013 Legislature.

■ REQUESTS FOR RESOLUTION ■

During the past year the Office of the Court Monitor received two Requests for Resolution. One resulted in an extensive report prepared by the Special Assistant available on the Court Monitor's website at www.courtmonitor.wv.gov. The other is pending agreement on a formal recommendation offered by the Court Monitor.

■ REQUEST FOR RESOLUTION REGARDING PATIENT ADVOCACY AND APPEALS ■

Petitioners also filed a Request for Resolution alleging that the current process for appeals regarding patient grievances was not effective and/or unbiased. The Court Monitor conducted a review of all appeals filed in the past year along with the resolution of those appeals. He also interviewed several staff, advocates and administrators. Ultimately he offered a formal recommendation that an amended order designate the Court Monitor as the appeal entity should the facility-level process fail to resolve a grievance. At the time of this writing, the language of the proposed order was being discussed by the Parties.

■ WEST VIRGINIA CIVIL COMMITMENTS ■

For the last several years the West Virginia Supreme Court of Appeals has been working on a data collection system for mental hygiene activities such as Final Commitment and Probable Cause. That system is nearing full implementation and the Supreme Court has been kind enough to share their data with the Office of the Court Monitor. Although BHHF has collected data in the past on commitments and probable cause admissions to state facilities, the data provided by the Supreme Court is more sophisticated and able to accurately track out of state commitments and juvenile commitments, separating probable cause hearings from final commitments. The Special Assistant has taken the data provided by the Supreme Court for calendar year (CY) 2011 and analyzed, by county, rates of probable cause per 1,000 census. Even when out of state commitments are filtered from the data, the top five counties of commitment are along the Ohio border (Wetzel, Ohio, Mason, Wood and Cabell). Kanawha county was the sixth highest. The lowest five, Morgan, Pleasants, Upshur, Ritchie, and Summers counties, tend to be more heavily rural with relatively few behavioral health and social services. It is very possible that the counties with high investment in services tend to attract individuals from outer counties, artificially increasing the commitment rate for those counties. Homeless shelters, programs providing meals, psychiatric units, and improved access to health care providers may account for some of the differential in that they provide services for individuals unable to obtain those services in their home counties. It should also be noted that counties with psychiatric emergency departments (EDs) (Kanawha, Cabell, Ohio, Wood, Raleigh, and Monongalia to name a few) will be more likely to have high rates of commitment due to the presence of those EDs.

Nonetheless, a few preliminary conclusions can be made, based on the data available to date. First, while the Supreme Court does not have data available for CY 2010, the data available from BHHF suggests that the number of individuals committed each year, and the total commitments (which includes individuals committed more than once), have declined minimally over the fiscal years (FY) between 2009 and 2012. There was a slow but steady decline between 2009 and 2011, but data from 2012 bounced back to 2010 levels. Comparing 2009 levels to 2012 levels, a decrease of individuals committed of about 3% was observed. During the same period, a 7% decrease in total numbers of commitments was achieved. Unfortunately this data is inclusive of final commitment as well as probable cause, and therefore does not crosswalk precisely with Supreme Court data. The Supreme Court reports 442 final commitments occurred in calendar year 2011.

Commitment data for a four year period
Data supplied by BHHF

Year	Number of individuals committed	Total commitments
FY 2009	3,391	3,664
FY 2010	3,263	3,496
FY 2011	3,177	3,346
FY 2012	3,277	3,405

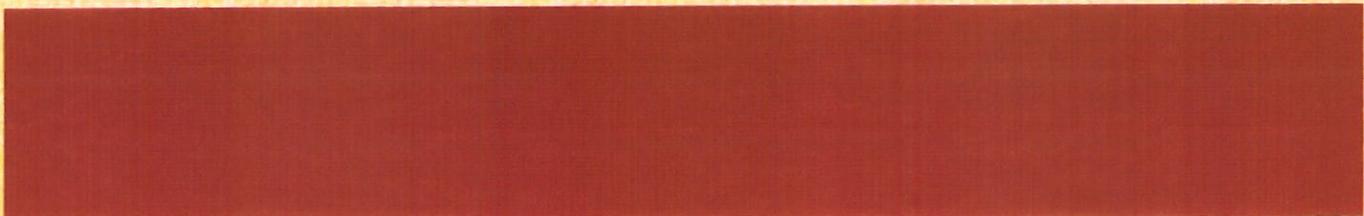
Second, the percentage of individuals with substance abuse complications remains very high, by examination of clinical records by the Special Assistant. This creates a situation of continuing high rates of commitment due to the recidivating nature of individuals struggling with recovery. While some of the supported living funding mandated by the Agreed Order was transformed to short term substance abuse treatment beds by agreement with the Parties, the demand will outstrip the treatment capacity for the foreseeable future. Fortunately the plague of commitments of individuals who have become psychotic due to bath salt use has decreased somewhat since new legislative prohibitions were put into place (bath salts abuse remains problematic in some areas of the state).

Third, the majority of the population of both state facilities and of diversions due to civil commitment turns over rapidly. Patients who end up spending extended terms in facilities do so because their illness or behavioral issues require that supervised placement be identified by social work staff.

Twenty four hour supervised housing and nursing home beds capable of dealing with individuals with severe and recurring mental illness are two of the few interventions which hold any hope of decreasing the small but stable population of individuals requiring long term institutionalization due to the severity of their mental illness or behavior problems. This population requires constant supervision and in some cases, skilled nursing care. Even with that support, rate of failure in community placement is high in programs accepting the more challenging consumers. The Prestera Center, for example, has been very aggressive in accepting consumers with severe illness into their supervised living placements (somewhat less than 24 hour on-site supports with Assertive Community Treatment as an additional resource). The program has struggled with individuals who are reluctant to take medications in a community setting and therefore regress into psychosis, or who become aggressive with staff or other residents, sometimes due to substance abuse.

Since almost all nursing homes operate at full capacity, they have no need and lack the skilled personnel to deal with difficult patients with mental illness frequently complicated by dementia.

These interventions (24 hour group home and nursing home care) are costly to operate and staff difficult to recruit therefore their potential is circumscribed by the resources available. Additionally, the cost-effectiveness of operation of small group homes with high staffing ratios must be carefully evaluated, as must the potential possible threat to the health and safety of the resident(s) and the public. Work force recruiting and retention is an on-going problem throughout the system.



CASE MANAGEMENT

Pursuant to the order of the court dated August 7, 2009, the West Virginia Department of Health and Human Resources (DHHR) was required to obtain the services of an expert to assist the Court and DHHR in the review of DHHR's utilization management guidelines that govern authorization for community mental health services. With the concurrence of the attendees of the Meeting of the Parties conducted by the Court Monitor, consultants were selected. Clinical Services Management, P.C. of Midland Park, New Jersey, (CSM) spoke with DHHR officials, providers and persons from the Court Monitor's Office as a part of their review and report. The written report is over 200 pages and contains a variety of recommendations.

After receiving the report, the Department convened a group of individuals to review the report in detail and to bring forward a plan for action on the topics. The group contains representatives from providers, BHHF staff, BMS staff, representatives of advocacy groups, and persons from the Secretary's Office. Over the course of the year in which the group has been meeting, it has learned much about the State Plan approval process and the intricacies of Medicaid billing. A cooperative spirit has also been developed.

The tasks ahead of DHHR with regard to the delivery and funding of behavioral health services in the post-Affordable Care Act era are daunting. New guidance from CMS and other federal agencies is received weekly. Medicaid expansion is in flux on a national basis since the U.S. Supreme Court's recent ruling. And all of this is occurring against a backdrop of belt-tightening on a state basis, with Medicaid being portrayed in the media as the major cause of the state's financial problems. Therefore, it was proposed that the group that has come together informally to review the CSM Report continue to meet with a broadened scope to more generally consider the developing issues. The purpose is not to dismiss or ignore the specifics of the CSM report; rather, to look at it now with a new perspective. The group would also continue to serve as a sounding board for new ideas and a forum for airing problems and issues.

TRAUMATIC BRAIN INJURY

The Traumatic Brain Injury Waiver (TBI Waiver) program began February 1, 2012. The Center for Medicaid Services (CMS) approved the TBI Waiver for 75 slots the first year and an additional 25 slots the second and third year for a total of 125.

The TBI Waiver Program is a long term care alternative that provides services that enable individuals to live at home rather than receiving care through a facility. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate. APS Healthcare Inc., contracted by Bureau for Medical Services (BMS), is responsible for the day to day operations and oversight of the TBI Waiver program. This includes conducting the medical evaluations; determining medical eligibility for applicants and members of the program; and performing provider agency certification.

Since the program implementation, APS Healthcare has received, processed and made initial determinations on twenty-one (21) - Medical Eligibility Request Forms (MNER)/applications.

- Of those 21 applicants:
 - 2 were initially reviewed to be ineligible because they did not come from an approvable referral source;
 - 2 legal representative withdrew the application;
 - 2 facility withdrew the application; and
 - 0 were initially reviewed to be ineligible because they were not 21 years of age
- The remaining 15 applicants received the Preadmission Screening (PAS) to determine medical eligibility/nursing level of care.
- Of those 15, 10 applicants were considered medically eligible based on their PAS and Rancho Los Amigos scores. Of the 10,
 - 2 applicants were denied financial eligibility;
 - 6 applicants are awaiting determination of financial eligibility;
 - 1 facility withdrew the application due to no home/community setting for the applicant; and
 - 1 enrolled member is currently receiving service

Since the program implementation, APS Healthcare has conducted five hundred and sixty four (564) targeted outreach contacts with licensed nursing facilities, inpatient hospitals, licensed rehabilitation facilities, Aged & Disability Resource Centers, Ombudsman personnel, and other potential referents. These outreach contacts are designed to increase awareness of the TBI Waiver Program, and to explain the application process.

Thirty-six (36) enrolled providers have been established with the Medicaid TBI Waiver Program. Statewide coverage is available for both the Case Management and Personal Attendant services. Twenty-three (23) counties have Cognitive Rehabilitation Therapy provided by the following Licensed Behavioral Health Centers (LBHC):

1. Appalachian Community Health Center
2. Council of the Southern Mountains
3. East Ridge Health Systems
4. The Family Service of Marion and Harrison County
5. Pretera Center for Mental Health Services
6. WV Family Support and Rehabilitation Services

The TBI Waiver Quality Improvement Advisory Council was established and held its first meeting on August 15, 2012. The Council members, representing a variety of statewide stakeholders, are tasked with the responsibility to provide BMS and APS Healthcare with recommendations for policy or process changes that would benefit the program.

AGREED ORDER

According to the Agreed Order, signed by Judge Bloom in 2009, the DHHR was to have provided funding for the following by the end of Year Three:

- Seven group homes totaling 56 beds;
- 143 supportive living slots; and
- Seven day treatment programs.

The DHHR has made the funding available as required. Community implementation has been slowed by the need for construction and renovation on some projects. Also, not all of the supportive living slots were requested by community providers, causing a pool of about \$1.08 million to be distributed evenly among the 13 Comprehensive Centers for community-based projects (some of which were supportive living).

As of July 27, 2012, the status of funded programs as reported by the providers was as follows:

- Pretera Center (Charleston, Huntington and multiple outlying counties):

- Three group homes totaling 14 beds in Huntington and four in Charleston;
- Eight supportive living slots in Huntington and eight in Charleston;
- Two supportive living slots in Mason county; and
- One day treatment program in Huntington subcontracted to the Consumer's Association.
- The Huntington and Charleston group homes and supported living programs are fully utilized. No report was available on Mason county.
- Additionally, Pretera was funded for 6 detoxification beds in the new Pinecrest Center in Huntington.

- Westbrook (Parkersburg and outlying counties):

- Roane County: three supportive living slots;
- Jackson County: three supportive living slots;
- Wood County: 11 supportive living slots serving 36 individuals;
- Day program for Roane and Jackson counties;
- One group home for six beds in Parkersburg; and
- One day treatment program and a drop in center in Parkersburg.

- FMRS (Beckley and outlying counties):

- 25 supported living slots serving 18 people currently (full capacity by end of August projected); and
- One non-site based day treatment program serving the 18 supportive living individuals.
- FMRS also received funds for three care coordinators/crisis workers assigned to the BARH emergency room and inpatient program for linkage and referral.

- Southern Highlands (Princeton and outlying counties):

- One group home currently under construction scheduled to open October or November; and
- 16 supportive living slots serving 49 individuals.

- United Summit Center (Clarksburg and outlying counties):

- One group home for eight beds opening in August;
- 18 supportive living slots converted to an 18 bed short term substance abuse treatment unit currently being renovated and expected to open in Fall of 2012; and
- One day treatment program in process of renovation and scheduled to open in Fall of 2012.

- Healthways (Brooke and Hancock counties):

- Two supportive living slots not yet funded in grant agreement. In process of being resolved.

- **Eastridge** (Martinsburg and Eastern Panhandle counties):
 - Grant to reserve one bed in step down unit for individuals whose commitment has expired but no placement yet located (has served three individuals to date).
- **Northwood** (Wheeling and lower part of Northern Panhandle):
 - One group home serving eight individuals;
 - 24 supportive living slots serving 33 individuals at the present time; and
 - One day treatment program serving 55 individuals.
- **Valley Health Systems** (Morgantown and outlying counties):
 - Four supportive living slots serving five consumers at present; and
 - One day treatment program serving 22 individuals.

Summary

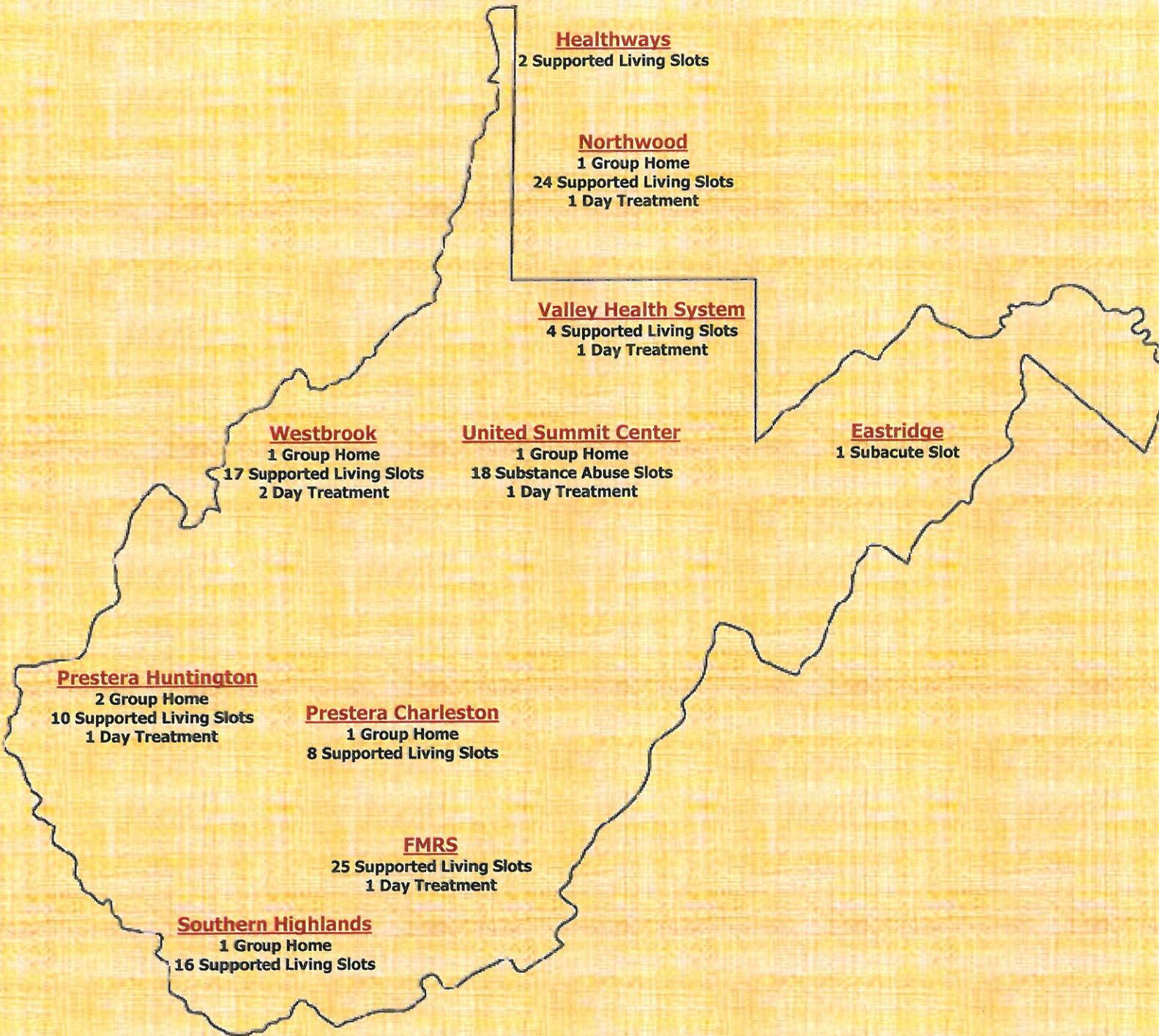
All of the group homes are currently allocated. Five of seven are open and two are scheduled to open in the next six months. All of the day treatment programs are allocated. Six are open and one is scheduled to open within six months. 134 supportive living slots are funded (18 of the 124 were converted to substance abuse treatment in Clarksburg). Funding for the remaining supportive living slots was converted to a variety of community based programs statewide with the agreement of the Parties.

AVERAGE MONTHLY CENSUS OF STATE PSYCHIATRIC HOSPITALS

Average Monthly Census of State Psychiatric Facilities August 2011 - August 2012



Program Development Map for 2009-2012



Reports issued by the Office of the Court Monitor may be accessed at www.courtmonitor.wv.gov.

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