Mayview Regional Service Area Plan (MRSAP)
Revised Planning Document

Submitted by the Counties of:

Allegheny
Beaver
Greene
Lawrence
Washington

July 25, 2007

Mayview Regional Service Area Plan

Allegheny, Beaver, Greene, Lawrence and Washington Counties have spent the past three years planning and working together on building stronger community systems to help individuals return home from Mayview State Hospital, avoid hospitalization at Mayview or – if individuals do go to the state hospital – to make their stay as short as possible. From the outset, the counties have been committed to doing this in a recovery oriented fashion which we believe is reflected in this plan and in the various processes that have been or are being developed to facilitate this regional planning process. This approach has formed the basis for the five counties, working with a variety of stakeholders, to develop a Mayview Regional Service Area Plan. This document reflects an update to the plan and covers activities as of June 30, 2007.

It is important to understand the work the counties have done over the past few years and how this work has had an impact on the counties' planning efforts for the future and on the patients at Mayview State Hospital (MSH). While there is necessary talk and planning about resources and bed closures; the heart of the discussion is really about how to improve lives for individuals and build stronger community systems of treatment and informal supports while building on natural supports to assist individuals on their road to recovery.

Work to Date

The five counties initially had worked together on submitting a Service Area Plan about four years ago. The feedback from Department of Public Welfare (DPW) on that plan, however, suggested there was a need for the counties to be more specific in their plans, show better use of data, and show greater evidence of "regional" planning. While the counties recognized the need to heed the feedback from DPW, the counties also wanted to plan for a significant increase in community services and supports using resources available through Mayview State Hospital, maximizing HealthChoices resources and redirecting existing service dollars as needed.

This common goal was a strong impetus for them to come together and to work collaboratively on building stronger community systems. The four suburban counties also wanted to close several beds at the hospital, knowing those resources would be necessary to make the improvements needed to community systems but realized that they would be more likely to achieve their goals if Allegheny County participated in the process. Allegheny County agreed to participate. Although all the counties have been involved in bed reduction efforts over the past several years, the importance of this effort has been the collaborative planning that has occurred. After discussion among themselves, the counties felt they needed some additional assistance in the planning process and contracted with Allegheny HealthChoices, Inc. (AHCI) to coordinate the planning process.

The counties quickly decided to involve key stakeholders to plan for future use of Mayview State Hospital and assist in determining key service and support needs in the community. This was driven primarily by three factors including the belief that individuals should have every opportunity to live in their home communities, the feeling they needed to be ready in the event DPW decided to significantly downsize or close Mayview and the recognition that the state hospital budget is likely to be the most significant source of new dollars for enhancing community systems. Within that context, the counties began to view the planning and process for closing the first 25 to 30 beds (one unit) as the process for building the infrastructure and planning processes to more significantly reduce utilization of Mayview State Hospital over time. That process in which the counties were engaging in at the time of the initial service plan development is known as Wave 1 or Phase 1. The Counties have subsequently completed Phase 2 which is a further reduction of 30 beds, or a second unit, at the hospital. An additional four beds have been closed and will be counted toward the closure of another unit. This plan reports on those activities and additional planning activities that are occurring to allow for further enhancements of community services and supports and subsequent reductions in utilization.

Planning Structure

The five counties moved quickly to put in place a planning/coordination structure to implement this effort and use going forward in working together around Mayview utilization and county/regional community service development. The structure initially, was as follows:

- A *Steering Committee* comprised of the administrators from the five counties; consumer and family representatives of Allegheny and the suburban counties, provider representatives, advocates, Mayview State Hospital's leadership, Value Behavioral Health-of PA (VBH-PA) and Community Care (local managed care organizations), AHCI staff and representatives from DPW. The Steering Committee oversees all aspects of the project and is the primary decision making group. This group has remained intact throughout the process. Recently, however, the decision was made to add psychiatric capacity to the committee and three psychiatrists have been invited to join the committee. Also, the Chair of the newly formed Quality Management Committee will become a member of the Steering Committee.
- An *Assessment and Discharge Planning Committee* comprised of approximately 50% consumers, including patients from Mayview State Hospital; hospital staff; hospital liaisons from the community providers; DPW staff and representatives of the five counties. This committee was charged with developing the assessment tools, coordinating and overseeing the assessment process, and developing and monitoring the community support planning process (formerly known as the discharge planning process).
- The *Finance Committee* comprised of the administrators of the five counties with staff and consultant assistance provided by AHCI. The goal of this committee has been to develop a structure for long – term stable funding. The group has wanted to move away from a traditional model of funding associated with the Community Hospital Integrated Program Projects (CHIPPs) and develop a model that provides more flexibility within the region and provides greater stability over time. The

committee also was responsible for any information system solutions to support the initiative.

Since the drafting of the initial plan, the committee structure has been modified somewhat to reflect the project needs and the counties' commitment not to have "committees for committees" sake.

The Assessment and Discharge Planning Committee continued its work through a revision of the assessment tools and Community Support Planning (CSP) process following Phase 1. At that point, there was discussion about the continued need for the committee serving in that capacity. There has been tremendous participation by consumers on that committee and there is a strong feeling about wanting to keep the group involved in a meaningful way. Thus, the decision was made to ask the group to assume a new role (and name) and become involved as the quality management committee for the process.

Quality Management Committee

The Quality Management Committee will be reviewing aggregate information on CSPs and the tracking information on individuals who have been discharged. The counties feel this is an important component for monitoring this initiative and for looking at its impact on consumers on an ongoing basis. Thus far, the committee has met one time and will be reviewing a draft Quality Improvement/Monitoring Plan at its next meeting. In addition, the committee has selected a Chair who will become a member of the Steering Committee.

As the work of the counties progressed, they saw the need for several other committees. These committees were viewed as ad hoc committees because they were formed for very specific purposes and were time limited. These committees included:

- *Tracking Committee* - It is comprised of a variety of stakeholders and is responsible for developing a common tracking process and form across the five counties. This includes a set of early warning indicators to trigger a response or follow-up by the counties for persons discharged. This group has also worked on developing a core set of questions that Consumer Family Satisfaction Teams (CFSTs) from the five counties will be asking the persons discharged through the CSP process.
- *State-operated Services* – The counties recognized that many state hospital employees have skills and knowledge that would benefit the consumers who are discharged and perhaps help fill gaps in community systems. The counties also recognized it is imperative that any services operated by the state be consistent with county and client needs, so they formed a committee to begin exploring those possibilities and have come up with several options presented later in this document.
- *Front Door/Diversion Committee* – As the number of beds at MSH is reduced, it is important to address the demands for services at the front door, i.e. the point of referral to community inpatient services or to Mayview. The committee evolved somewhat and became primarily a committee of the four suburban counties and began looking at overall system needs focusing specifically on issues of single point of accountability (case management and community treatment teams), crisis services

and housing. Allegheny County, through its Change Management Committee, is examining the same issues.

The State Operated Services Committee and the Front Door/Diversion Committee no longer function as independent committees; rather, the members of those committees have come together with the administrators to develop more concrete plans based on their deliberations. The result of their work is discussed later in this plan.

Preparation for Phase 1

In preparation for Phase I, the counties developed an assessment process modeled on the process used in the consolidation at Harrisburg State Hospital, although the assessment instruments were significantly modified based on consumer input from the five counties. Individuals selected for assessment were identified through a collaborative effort of the counties and state hospital staff focusing on individuals with lengths of stay greater than two years. Thirty eight individuals were assessed with the goal of identifying 30 people for discharge. Upon completion of the assessments, facilitated community support plan (discharge planning) meetings were held to ensure adequate planning for patients returning to the community.

This process began to push the participants to "think outside the box." The results have been that far fewer patients than typical have been determined upon discharge to need locked residential care or highly structured group living. Community Support Plans are becoming more focused on helping clients find homes in clustered apartment settings with more limited on site staff and or settings which emphasize the provision of community support services by providers. This is a challenging population given the long lengths of stays of these patients, the highly complicated medication regimens, institutionalized behaviors and serious co-morbid medical conditions. This represents the beginning of a significant shift in thinking about the possibilities for community living for people discharged from a state hospital. The emphasis increasingly is on bringing in supports to the greatest extent possible by relying more extensively on community treatment teams and intensive case management.

Phase I (completed)

In Phase 1, the five counties discharged 30 individuals who had been at Mayview two years or longer and 30 beds were closed following those discharges. The individuals discharged went to a variety of living situations and have remained in those situations with community services being provided by providers across the counties. Individuals were discharged to four counties; Greene County did not have anyone in the hospital over two years. In order to support those clients discharged and to continue community service enhancement, DPW allocated $3.2 million for the five counties. The counties are using those funds to support the CSPs of the consumers in Phase 1 and to develop or enhance several services including crisis services, community treatment teams, and case management. In addition, several counties have proposed to utilize reinvestment dollars in support of this effort.

Initial Outcomes for Individuals in Phase 1

The counties are closely tracking how each person discharged is doing and following up to ensure that the CSP is being implemented as developed or is being modified to provide supports consistent with the client's needs as they may change over time. Provider meetings have been held in all counties to ensure they understand the Service Area Plan (SAP) initiative and their responsibilities for the use of early warning indicators to intervene with a client and to do "whatever it takes" to support people in the community. The SAP initiative is resulting in incremental system changes that are making it possible for people to live in their communities.

- Not one person has been readmitted to the state hospital
- Allegheny County has significantly reduced referrals to the state hospital
- A small but increasing number of people are working, volunteering or taking part in educational activities
- One person is receiving peer mentor services (as a continuation of peer support started in the hospital)
- Few people have been rehospitalized and those rehospitalizations generally have been very short

Phase 2 – Lessons Learned from Phase 1 and Phase 2 Implementations

The counties have recently completed implementation of Phase 2, the discharge of 30 individuals from Mayview and the reduction in capacity of another 30 beds at the hospital. While the process has essentially the same as for Phase 1, some notable changes were made based on lessons learned from Phase 1. These changes included:

- Further modification and refinement of the clinical assessment in an attempt to get more complete, accurate and up to date information on the clients with whom CSPs are being developed
- Designation of a lead facilitator and enhanced training of facilitators and recorders in order to improve the consistency of the CSPs and provide more follow-up on tasks and more opportunity for intensive record reviews, etc.
- Increased participation of community staff in CSP meetings
- Clearer identification and specification of the steps in the CSP process
- Shorter CSP meetings to improve client participation for the complete process
- Budgeting in a manner that provides increased flexible dollars and less initial reliance on trying to fit clients into the existing types of programs in the communities
- Earlier involvement of key community staff to both enhance the development of the CSP and the implementation of the CSP once the client is discharged
- Establishment of outreach to people in the hospital by peer mentors to begin engaging people for whom the hospital has become a home over the years and who may be fearful of leaving

In support of these activities, a website application was developed to assist and facilitate improved communication and document tracking. This application is continuously updated to improve its functionality.

In addition to those issues, the counties are being very deliberate and intentional in planning activities and in putting into place processes that ensure they are kept up to date on the status on clients in the community. Many of these activities are referenced in other sections of the plan, but to summarize, they include:

- Emphasis on regional planning for key service areas and regional service development when indicated
- Consideration of areas in which state operated community services can enhance community systems
- Use of tracking data to improve the quality of services
- Increasing the availability of flexible dollars to help CSP participants "think **and act** outside the box"
- Reviewing current services to ensure they are operating as best practices
- Exploring and utilizing informal community supports and natural supports

Phase 2 – overview of discharge information

As of June 30, 2007, 34 individuals were discharged through the CSP process bringing the total number of persons discharged to 64 with 64 beds closed following those individuals leaving the hospital. All of the individuals who have been discharged are receiving case management services; with 68% receiving services from one of several Community Treatment Teams operating in the counties. Many of the individuals discharged also are receiving support from peer mentors who they met while at Mayview and who are continuing to visit with them and offer support as they begin the transition to new homes in the community. Individuals who have been discharged are living in a variety of new homes including small, comprehensive personal care homes, supported housing, community residential rehabilitation homes, and small homes established specifically for the needs of the individuals. For all individuals, additional services and supports are part of the individuals' community support plans.

CSP Tracking System

All individuals discharged from Mayview as part of the CSP process are monitored and tracked via the website as part of a system developed by stakeholders from the five counties, DPW, and other stakeholders. The system is designed to insure that the services included in the CSP are being delivered or modified as needed, individuals are satisfied with the services and supports and their quality of life overall, and that providers are proactively working with individuals to help them achieve their recovery goals. The system is also designed to insure that providers are helping clients to avoid crises and continue their lives in the community. In order to collect the needed information, the system relies on face-to-face contact between county representatives and clients, reporting by providers, interviews with consumer/family satisfaction teams, and early warning reports of interventions of providers to avert crises. Data currently is reported to DPW

on a monthly basis. In the future it also will be reported in aggregate form to the Quality Management Committee.

County and Multi-County Planning for Services and Support Needs

For the past several months, the counties have been involved in system planning at several levels for purposes of enhancing the community systems of services and supports. The efforts of these planning efforts have begun to come to fruition through the implementation of several initiatives including:

- Finding housing that meets consumers' preferences and provides the flexibility for the level of staffing both consumer and staff have indicated is needed.
    - Suburban counties have hired a regional housing coordinator to develop and assist in implementing a regional housing plan
    - Three counties have developed specific housing arrangements for individuals based on the needs of the clients discharged from Mayview
    - Allegheny county has continued implementation of its permanent supportive housing plan
- Enhancing or expanding intensive case management services and/or community treatment teams to provide the level of in-home services needed.
    - All five counties have now implemented or are in the process of implementing Community Treatment Teams according to the Assertive Community Treatment (ACT) model (with some modifications for more rural areas and population to be served)
    - All five counties are planning for the implementation of a "Single Point of Accountability" to insure that responsibility for clients is clear and that clients know who they have as a primary point of contact with the system
    - Allegheny County also is implementing plans to enhance case management services by increasing the level of clinical support available to case managers
- Developing peer services and supports to address the isolation these individuals feel that they may experience in the community.
    - All of the counties have developed the capacity to provide peer mentor services to individuals while they are still at Mayview
    - Many of the CSPs call for the use of peer mentors in the community to continue to assist clients in the transition
    - Opportunities for developing Advance Directives, WRAPs, and Recovery Management Plans are being made available more consistently to clients

The counties also are evaluating their systems to ensure that current dollars are being spent in an optimal way including maximizing the use of HealthChoices dollars. They are making decisions regarding the current expenditure of funds to support the kinds of supports and services being

identified in the Community Support Plans and that are necessary to help individuals continue in their recovery process. In order to accomplish this, the counties are undertaking a variety of activities including:

- Review of individuals currently residing in Long Term Structured Residences and other highly structured residential environments to determine if they want to and can live in less structured settings
- Consideration of the conversion of social rehabilitation programs to psychiatric rehabilitation programs
- Review of reimbursement structures to support increased implementation of evidence-based practices and other recovery oriented services
- Development of contract incentives for Behavioral Health Managed Care Organizations (BH-MCO) to increase their attention to working with the community to divert individuals from unnecessary hospitalization or to make sure discharge planning is enhanced by community involvement
- Enhancement of crisis systems most likely requiring a redirection of other service dollars
- Review of case management services to ensure their capacity to provide the level of services needed
- Conversion of LTSR and Community Residential Rehabilitation (CRR) beds to Fairweather Lodge models
- Continued conversion of CRR beds to supported housing models

The counties also are looking at new service development through the use of funds transferred to the community for individuals' transition to the community. The types of services that will be required include:

- Supported housing in a “housing as home” model
- New or expanded community treatment teams
- In-home supports in addition to the level of care that might be provided by a community treatment team
- Clustered apartments or very small homes with limited live-in staff and most services provided by community treatment team or case management
- Extended acute care
- Non-hospital crisis capability
- Comprehensive personal care homes
- Peer support across a variety of settings and services
- Psychiatric supports for persons in nursing homes
- Mobile medication programs
- Contingency funds for a variety of things including helping individuals become established in their homes

The list above is not meant to be all – inclusive but perhaps best illustrates how flexible the counties are becoming in their ability to deploy services in support of individuals.

Service Area Plan for FY2008 and 2009

As the regional planning process has continued, the counties are proposing to continue the process developing CSPs for patients at Mayview State Hospital and extend that process to include all individuals in the CSP process, not only those who have been in the hospital for two years or longer. However, the proposed plans are contingent upon reaching agreement regarding the financing and timing of the plan.

During the period July 1, 2007 through December 30, 2008, the counties propose to continue to reduce the average daily resident population at Mayview State Hospital and to develop community-based clinical, residential and support services for everyone now receiving services at MSH and alternative, diversion services as a replacement for the Mayview State Hospital. This is consistent with earlier proposals submitted to DPW.

While the counties are proposing the following as a timetable for bed reductions at the hospital, this should be considered as tentative pending further discussions among the counties and with the hospital and DPW.

Start Census: 225

		Admissions	Total Discharges	Discharges-Admissions	Ending Census
QUARTER 1	Jul-Sept 07	27	42	15	210
QUARTER 2	Oct-Dec 07	18	42	24	186
QUARTER 3	Jan-Mar 08	12	45	33	153
QUARTER 4	Apr-Jun 08	12	48	36	117
QUARTER 5	Jul-Sept 08	0	54	54	63
QUARTER 6	Oct-Dec 08	0	63	63	0

This plan also provides for the counties to stop referrals to Mayview by April 1, 2008. Admissions shown for April 1 reflect individuals who may have already been referred. The counties intend to divert these individuals, but have left that number in the chart in the event circumstances prevent a diversion. The counties also recognize the need for there to be additional capacity to divert persons from the hospital before they can stop admitting to Mayview. As a region, the counties are placing the highest priority on the following as diversion services:

- Increasing extended care capacity especially in the suburban counties – Allegheny already has increased its extended acute care capacity. The suburban counties are planning on developing targeted extended acute care capacity and will consider doing

so on a multi-county basis. Initial estimates are that the suburban counties will develop capacity for 10 extended care beds.

- Enhancement of crisis systems in all five counties. The counties all have been working toward enhancing their crisis systems and continue in that effort. The emphasis in all the counties is on enhancing mobile crisis services, developing short term crisis residential services, and enhancing in-home crisis supports. The intent is not only to try to divert individuals from Mayview, but also to help divert admissions to acute care facilities.
- Enhancement of community treatment teams and case management to insure these staff are notified and involved in the decisions around admission and discharge of clients to inpatient units-
- Development of a diversion facility that can accept individuals on commitment and provide a secure environment for a period of up to six months. The counties estimate they would require 8 -16 beds for this and propose to develop on a regional basis with two sites. To the best of the counties' knowledge, this type of facility would have to be licensed as an LTSR, although they would be interested in other suggestions that DPW may have given all parties hesitancy to invest additional funds in LTSRs at this point.
- One on one capacity as diversions to help people stay in their current residence. Such a program could be used as a crisis program, planned respite, or support following hospital discharge.

Other Service Needs

Throughout this document, the counties have discussed some of the additional or enhanced services and supports that individuals will need to live successfully in the community and continue their recovery process. In addition to those already mentioned, there are at least three populations of individuals who the counties feel will require specially designed living arrangements. These include:

- Individuals with special or unique behavioral challenges. People with a wide range of behaviors may fall into this category; however, this population would represent a small percentage of individuals served. They feel that most people can and will be served in the variety of community living options available or being developed. There is a smaller group of people, however, who will need secure, structured living situations. These would not necessarily be large facilities, but rather homes that offer more intense supervision and greater security than many community residences.
- Individuals with dementia who do not need a nursing home level of care. The counties are proposing small, home environments with more intense levels of support, especially nursing/LPN support. The needs of these individuals also might be addressed by a small comprehensive personal care home with additional medical, as well as behavioral health, supports.
- Additional mobile medication capacity, especially in the suburban counties.

Role of State Hospital's Resources

The counties recognize that the resources available to direct toward community services does not have to be limited to monetary resources. They recognize that the resources of the state hospital staff also would be of value to the community in order to meet some of the needs for services and supports identified throughout this document. The counties have been including this possibility in their planning efforts and initially are proposing discussions with DPW around the following as state-operated services:

- Program for persons with special behavioral challenges
- One on one crisis, respite or in-home services
- Enhancement of mobile medication services

The counties believe that the management structure providing oversight to a set of state operated services also would be a part of the county oversight structure to monitor and track the status of individuals who are discharged from Mayview. They recognize that intense discussions and negotiations will be necessary to finalize any such plan. It is important, however, that these discussions begin immediately as they are critical to the counties' overall planning efforts.

Other considerations

In addition to the various issues outlined in this document, the counties are sensitive to ensuring that other issues are considered in this process:

- Development of increased peer mentor capacity with clearer understanding of the role of the peer mentor in the community
- Increasing the participation of external advocates in the CSP process – the counties will each be developing a plan to accomplish this
- Reaching agreement on where clients who are discharged from the forensic unit will be discharged to

Financial Considerations

The counties clearly put a significant amount of effort to plan for the needs of clients discharged from Mayview; they also put a considerable amount of thought and effort into how to finance this initiative.

The initial activity was to look at overall utilization of Mayview as compared to other areas. The consultant to the counties was able to easily obtain data from the Ohio system and determined there was sufficient comparability to make the comparisons valid. The utilization of Mayview compared to state hospitalization use in Ohio is illustrated below.

Service Area	CY 2004 ADRP	Estimated 2004 Population	ADRP/100K Population
Allegheny	227.0	1,250,867	18.15
Beaver	27.5	178,601	15.40
Greene	2.5	40,133	6.23
Lawrence	6.5	93,374	6.96
Washington	24.0	205,738	11.67
Service Area Total	287.5	1,768,713	16.25
Ohio	538.0	11,459,011	4.69

The difference in utilization is even more pronounced when taking into account that the Ohio state hospitals provide acute care while Mayview is strictly a long-term care facility. In addition, in all state hospitals in Ohio there are only 90 persons who have been in the hospital more than 90 days, compared with 165 persons at Mayview from the five counties.

The second comparison was to look at the pattern and funding sources of services provided to individuals who had been discharged from Mayview. The data indicate that approximately 80% of the services provided are funded by base dollars with only 20% paid for by HealthChoices dollars. While some of that is accounted for by persons who are not HealthChoices eligible, the driving factor is that individuals are generally discharged into residential placements that are not HealthChoices eligible and receive all their services in those facilities. It is here that the assessment and community support plan data dovetail nicely with the financial realities. Individuals generally don't want to go to the kinds of residential facilities they have been referred to in the past and, continuing that practice would not be financially viable. The counties recognized that reality and it has become a key consideration in developing the financial strategy.

Mayview Cost Profile

One of the first work tasks was the identification and timing of funding which will become available for community based services as utilization of Mayview declines and capacity is reduced over the two or three year time period. The consultant worked with Mayview staff to identify various cost components as variable, step-variable or fixed costs. The variable costs are subject to transfer on a per ward basis. The step-variable costs are not transferable until there is a significant reduction in direct service capacity (estimated to be two wards and greater). Fixed costs are not subject to transfer until all direct non-forensic service capacity is liquidated.

For Phase I, the counties, with the cooperation of the hospital, identified the variable costs associated with one ward closure. The counties also proposed and DPW agreed that the money would not be distributed on a per diem basis but as a lump sum amount to be distributed across the counties based on an agreed upon formula. This formula is a reflection of both prior utilization and county population. This approach does not penalize or reward counties for prior utilization to the extent a per diem distribution does so.

In budgeting for the use of these funds the counties used the following categories (and these categories will be used in subsequent budget submissions):

- Services and supports for persons discharged from Mayview
- Services and supports for persons averted from admission to Mayview
- Community based alternative services for persons currently in structured residential facilities who no longer require that level of care
- Enhancements to the current array of community services to better support the recovery needs of all persons at risk of intensive mental health treatment.

As referenced above, the counties also are trying to achieve a higher utilization of HealthChoices eligible services thereby providing a higher degree of flexibility for the use of the Mayview funds. The program and financial plans are responsive to the OMHSAS Service Area Plan Goal 1: No person will remain in the state hospital for more than two years.

Goals 2 and 3

Clearly, the counties have focused the vast majority of their group work in further of Goal I although they have had discussions around Goals 2 and 3. Those discussions have focused primarily on reaching agreement on what to measure and how to measure it. Going forward the counties will be able to report and their progress in meeting those goals and will do so.