Report on the HB 888/SB 176 Workgroup to Review and Develop Alternative Services and Placements for Individuals with Neurocognitive Disorders or Neurodevelopmental Disabilities

Virginia Behavioral Health Commission

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Neurocognitive Disorders and Neurodevelopmental Disabilities

Neurocognitive disorders
Decline from a previously attained level of cognitive functioning. Mood disturbances are indicators of cognitive decline.

Includes:

Delirium due to medical causes

Various types of dementia

Brain injury due to trauma, stroke, infection, and/or chronic substance use

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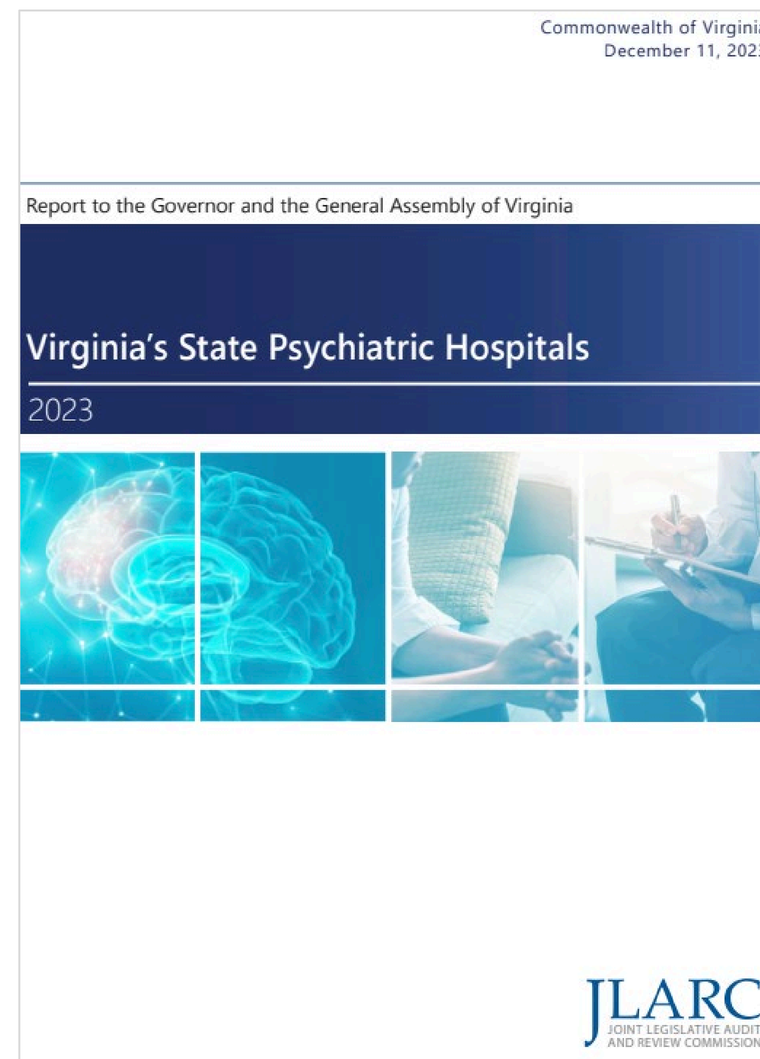
Neurodevelopmental disabilities
Onset in the developmental period, often before a child enters grade school. Developmental deficits that produce impairments of personal, social, academic, or occupational functioning.

Includes:
Intellectual Disability
Autism Spectrum Disorder
Global Developmental Delay
Speech-language disorders
Attention Deficit-Hyperactivity Disorder (ADHD)
Learning Disorders
Motor/Movement disorders

JLARC Report on Virginia's State Psychiatric Hospitals 2023

Key findings

- Individuals with a primary diagnosis of neurocognitive disorders and neurodevelopmental disabilities accounted for 10% of state psychiatric hospital discharges in FY 2023
- Individuals had longer lengths of stay
- Staff reported they lacked expertise to care for these patients, and were at higher risk of victimization
- SB176/HB888 is informed by the JLARC recommendations from the study



HB888 (Watts) / SB176 (Favola)

1. Specifies that **for the purpose of civil commitments and TDOs, behaviors and symptoms that manifest from a neurocognitive disorder or neurodevelopmental disability are excluded from the definition of mental illness** and are, therefore, not a basis for placing an individual under a TDO or committing an individual involuntarily to an inpatient psychiatric hospital.

Provides that if a state facility has reason to believe that an individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability, **the state facility may require that a licensed psychiatrist or other licensed mental health professional reevaluate the individual's eligibility for a TDO** before the individual is admitted and shall promptly authorize the release of an individual held under a TDO if the licensed psychiatrist or other licensed mental health professional determines the individual's behaviors or symptoms are solely a manifestation of a neurocognitive disorder or neurodevelopmental disability.

3. The provisions of the first enactment of this act shall not become effective unless reenacted by the 2025 Session of the General Assembly.

Workgroup Direction

1. Evaluate the current availability of placements for individuals with neurocognitive disorders and neurodevelopmental disabilities who would otherwise be placed in state psychiatric hospitals;

2. Identify and develop placements and services other than state psychiatric hospitals that would better support such individuals, especially individuals whose behaviors or symptoms are solely a manifestation of such disorders and disabilities, including through enhanced Medicaid reimbursements and a Medicaid waiver for individuals with neurocognitive disorders;

3. Specify any additional funding or statutory changes needed to prevent inappropriate placements of such individuals in state psychiatric hospitals;

4. Provide recommendations for training of magistrates and CSBs related to the implementation of this act.

Workgroup Process

5 Workgroup Meetings → Perspectives from families & advocates → Information shared from state agencies, providers, & national experts → Public Comment → Recommendation Review

Janet Kelly, Secretary of Health and Human Resources
Leah Mills, Deputy Secretary of Health and Human Resources

Senator Barbara Favola
Delegate Vivian Watts
Nathalie Molliet-Ribet, Behavioral Health Commission
Office of the Executive Secretary, Supreme Court of Virginia
Alzheimer's Association
The Arc of Virginia
Brain Injury Association of Virginia
Decriminalize Developmental Disabilities
Department of Aging and Rehabilitative Services
Department of Behavioral Health and Developmental Services
Department of Medical Assistance Services
disAbility Law Center of Virginia
The Faison Center
Mental Health Virginia
NAMI-VA

Partnership for People with Disabilities
Psychiatric Society of Virginia
Sevita Health
Virginia Autism Project
Virginia Association of Community Services Boards
Virginia Board for People with Disabilities
Virginia Association of Chiefs of Police
Virginia College of Emergency Physicians
Virginia Health Care Association
Virginia Hospital and Health Care Association
Virginia Network of Private Providers
Virginia Sheriffs Association
Vocal Virginia
Family Members

State Psychiatric Hospitalization for Individuals with ID/DD

The Commonwealth has significantly decreased the number of individuals with neurodevelopmental disorders being admitted to state psychiatric facilities due to the multiple investments made into community-based services.

Number of People with DD Admitted to State Psychiatric Facilities by Fiscal Year

	FY17	FY18	FY19	FY20	FY21	FY22	FY23	FY24*
Total admissions w/DD -state hospitals	626	727	1018	708	588	373	345	189
ADULTs w/DD admissions- state hospital	396	460	701	478	387	270	242	136
Children w/DD admissions- state hospitals	230	267	317	230	201	103	103	53

FY24 – Q1 and Q2 data only

Integration of Behavioral Health into Existing Settings

Carrington Memory Care

Tidewater Cover Dementia Care

Nursing Home Partnerships

RAFT Dementia Support Program

Wythe House

Integrated behavioral health care models through public-private partnerships has been effective and existing pilots have demonstrated low re-hospitalization rates (~3%).

However, there are additional procedural challenges for individuals under a TDO/ECO, i.e., individuals must participate in these programs on a voluntary basis and the time frame to coordinate care is limited under an ECO.

National Best Practices: Continuum of Services Clinical Criteria

Inpatient

- most severe and treatment-resistant problems
- at high risk for injury or are injured
- requires intensive management
- not safe to transport to the clinic
- Have had inpatient/outpatient services
- may need pharmacological intervention for psychiatric targets

Intensive Outpatient

- more severe and treatment-resistant
- requires rapid treatment
- safe to transport to the clinic
- have had prior outpatient services

Outpatient

- moderate severity
- safe to transport
- services have been limited to date

Critical gaps must first be filled

Finding

There are limited alternatives outside of state hospitals for individuals with neurocognitive disorders and neurodevelopmental disabilities who are in crisis.

The current landscape of services is not sufficient to meet the needs of individuals with neurodevelopmental and/or neurocognitive disorders with serious behavioral symptoms.

It is clinically challenging to determine if behavioral symptoms are solely due to a neurodevelopmental/neurocognitive disorder, especially in the 8-hour ECO time frame.

State hospitals may be the only option for many individuals with complex presentations and needs.

Recommendation

The workgroup agreed with the intent of the bill and commends the patrons for introducing the legislation. However, the workgroup expressed concerns regarding the current language as written, as it would not achieve the goal of ensuring appropriate placement options for individuals with neurocognitive/neurodevelopmental disorders, experiencing a behavioral health crisis, therefore, *recommended against re-enactment at this time.*

Build Out a Sustainable and Comprehensive Continuum of Care

Finding

Individuals in crisis should be served in the communities where they reside, close to their supports and services.

There are major gaps in the current available service array for individuals with neurocognitive/neurodevelopmental disorders.

There are successful programs administered through DBHDS, including innovative pilot programs operated by the CSBs in partnership with private providers, however capacity is limited.

Recommendations

Support planning and implementation of an applicable Medicaid waiver to build a continuum of home and community-based services, from crisis to long term supports, and increase access to brain injury and other neurocognitive services. Coverage for inpatient and residential neurobehavioral treatment should included.

Continue to build and expand a continuum of home and community services, from crisis to long term supports.

Expand the current pilot (Item 296 P2 of FY25-26 budget) to provide discharge assistance program (DAP) funding to private hospitals to assist with appropriate housing and support for individuals after discharge from hospitals.

Enhancements to the Crisis Services

Finding

Individuals in crisis should be served in the communities where they reside, close to their supports and services.

The current comprehensive crisis services are building out their capacity to meet the individualized needs of those with neurodevelopmental and/or neurocognitive disorders experiencing a behavioral health crisis.

Recommendations

DBHDS should continue to identify the resources and training needed for supporting the REACH program, and learn from the gaps of the program, to further expand capability to ensure it meets the immediate needs of individuals with neurodevelopmental disorders.

Ensure that Crisis Receiving Centers (CRCs) and Residential Crisis Stabilization Units (RCSUs) build capacity and competency to support the needs of individuals with neurodevelopmental and/or neurocognitive disorders (e.g., sensory rooms, designated space for caregivers to stay with the individual receiving services, protocols for funding and implementing increased staffing ratios when needed).

Enhancements to Existing Community Inpatient Settings

Finding

Individuals whose behaviors are a sole manifestation of neuro-developmental/neurocognitive disorders may still be a significant danger to self and/or others and require high intensity behavioral health services including in-patient care.

Nearly all private inpatient facilities in the state have neurodevelopmental disability and neurocognitive disorder as an exclusionary criteria for admission, due to lack of appropriate environment or clinical services to meet their needs.

Individuals in stable residential placements can experience displacement due to a behavioral health crisis and are unable to return to their previous living environment.

Recommendations

Expand the capability of private facilities to be able to serve more individuals with behavioral challenges who need inpatient care.

Support and build capacity among community providers to provide crisis intervention on site and/or readmit individuals referred to crisis services after stabilization, through expansion of integrated behavioral health services.

Enhancements to Existing Community Inpatient Settings

Finding

Individuals lack access to services and clinicians with the specialization required to meet their needs and existing providers cannot access expert consultants to support individuals in the least restrictive environment.

Recommendation

Develop a plan/partnership to establish a best-in-class treatment and rehabilitation center in Virginia for individuals with neurodevelopmental disabilities, that includes a high intensity behavioral health services specialty care unit, outpatient, and crisis services.

Workforce training

Community partnerships

Community consultation services

Caregiver education & support

Academic research and innovation

Communication and Information Sharing

Finding

Communication barriers can result in inadequate assessments, inappropriate placements, and/or longer lengths of stays.

Caregivers/legal decision-makers must receive comprehensive information to support individuals in crisis.

Lack of information sharing contributes to poor care and outcomes.

Recommendations

Review and enhance requirements for policies and procedures for involvement of family/caregivers throughout the crisis response and intervention process.

Develop a best practice protocol that defines stakeholder roles and responsibilities, including sharing clinical information, for providing diversion services to these individuals who present in the emergency department.

Build Workforce Capacity and Competency

Finding

The workforce needs ongoing support to develop the skills, capacity, and competency to provide high quality care to individuals with neurodevelopmental/neurocognitive disorders, including:

- Clinical expertise among practitioners and service providers
- Service-specific training
- Crisis response and intervention
- Administrative and operational supports to ensure the appropriate environment of care

Recommendations

Implement comprehensive training programs for staff at state and private hospitals to develop and demonstrate competency in supporting individuals with neurodevelopmental disabilities and neurocognitive disorders.

Create and implement a training curriculum for comprehensive crisis response and intervention for individuals with neurodevelopmental disabilities and/or neurocognitive disorders with challenging behaviors.

Identify funding resources for provider development and training on assessment and effective treatment for individuals with neurocognitive and/or neurodevelopmental disorders.

Support Caregivers

Finding

Caregivers play a critical role in supporting individuals in the least restrictive settings, advocating for their needs, and preventing unnecessary placements in state facilities.

Individuals and families need to have the ability to express their choices for care, which can be more difficult during times of a behavioral health crisis.

Recommendations

Identify appropriate funding mechanisms to support expanding access to respite care providers.

Review and strengthen policies to ensure family members and caregivers have multiple options for visitation (including in person, video, and telephonic), communication, ability to provide support and advocate for individual needs across service settings.

Identify and implement strategies to simplify the process of creating psychiatric advanced directives. Build infrastructure to ensure providers can access these directives, and educate stakeholders on creating, accessing, and implementing them.