



Human Services and Public Safety Policy Committee (HSPSPC)
Draft Bi-Monthly Meeting Minutes
Friday, November 20, 2015 at 12:30 P.M.

777 North Capitol Street, NE, Suite 300, Washington, DC 20002
Walter A. Scheiber Board Room

1. WELCOME, ANNOUNCEMENT(S), AND APPROVAL OF MINUTES

Walter Tejada, HSPSPC Chairman

Chairman Tejada opened the meeting at 12:30 P.M., noting that today's meeting is delayed to accommodate for a previously scheduled meeting. This meeting will focus on health in all policies.

Chairman Tejada motioned to approve the September 18, 2015 meeting minutes. The motion was seconded and unanimously approved.

2. HEALTH IN ALL POLICIES

Dr. Steven Woolf, Virginia Commonwealth University

The topic of *Health in All Policies* (HiAP) acknowledges the need for public policy makers and elected officials to refocus when considering improving healthcare related policies and procedures for community healthcare facilities. Dr. Woolf suggested that there be a broader view beyond the scope of hospitals, public healthcare facilities, and physician offices. He noted that policies when administered correctly can play an enormous role and provide positive outcomes when targeting common illnesses and identifying the causes of premature deaths in the region.

Research has shown that healthcare cost drivers are related to personal behaviors and the conditions in a particular setting. In the hospital, patients are often cured of diseases, but then return to an environment that may have been the root cause for them getting sick in the first place, resulting in frequent re-admissions or bounce-backs to the emergency room. Healthcare providers and policy makers should work to better identify and monitor exposures to environmental health risk and address personal behaviors (i.e., air pollutants, gun control, cigarette smoking, lack of space for exercise, and the number of fast food restaurants and liquor stores in close proximity, etc.). Officials need to place greater focus on factors outside of the traditional healthcare arena to better identify remedies for preventive healthcare.

Dr. Woolf noted that a good model for reference would be *The Robert Wood Johnson Foundation*. The Foundation is currently funding experiments where life expectancy around segments of the United States is measured, and has been successful in establishing a *build healthy network*, which tracks populations who have agreed to work on improving healthcare in designated communities. This network has metrics that track progress to ensure the community is meeting established goals with a focus on removing those things that reduce life expectancy where possible.

Discussion:

- Collaboration is required with policy makers, elected officials, and healthcare providers to develop shared goals, ideas, and specific targets. Health-in-all-policies should be intentional in design and not have a narrow focus for a particular agency, i.e., law enforcement or healthcare, but should rather take an overall approach that reaches across all spectrums.
- Initiate efficient and targeted data collection with the community and healthcare leaders to address health related issues, associated with behavioral health area (deal with mental health and substance abuse). Pull together data in real-time that will assist policy makers in strategizing and making decisions.
- Determine if the transportation system is facilitating or hindering activities amongst residents, particularly those activities that are important to improve health. For example, commuting gaps to include highway designs that cut-off neighborhoods that reduce easy access to jobs, health care, and childcare.
- There is a spike in persons incarcerated who actually suffer from mental illness. Imprisoning those with mental health issues is not the right solution, but due to the lack of facilities to house this population, prisons and jails hold the responsibility for retaining and caring for them.

3. INITIATIVES FOR BEHAVIORAL HEALTH SUPPORTS IN DISASTER AND EMERGENCY SETTINGS

Kevin M O'Brien, DC Department of Behavioral Health

Mr. O'Brien presented an overview of behavioral health initiatives in the District of Columbia that are related to emergency and disaster support and continuity of operations. He discussed training activities and interesting collaborations that have been developed in the District of Columbia. He noted that the real goal of disaster behavioral health support is to build resilience in the community on the family level, mitigate the future of adverse effects of traumatic events, and increase the public's reliance and belief in government so that they are less anxious about future emergencies.

The District of Columbia has an All Hazard Response Plan that is consistent with the National Incident Management System and the Incident Command System. In the event of an emergency, the community's health and safety needs take precedence over issues related to behavioral health. The Department of Behavioral Health (DBH) staff do not serve as first responders. They are normally requested to go to a scene once the area is safe.

Once on the scene, the behavioral health responders role is to lend support to those directly affected, and provide backup support to community social services that may have been impacted by the disaster. Overall, most people do well; however, there is a small population who may develop adverse effects and will need on-going assistance. The DBH has the responsibility for monitoring the progress of persons in its care. This responsibility does not fall to the Red Cross. For example, they provide disaster and behavioral services in cases of large-scale fires and help locate emergency housing. They work with the DC cold weather emergency units. They support homeless individuals, National Security events, victims of mass shootings, and the Mayor in responding to request for assistance.

DBH provides routine day-to-day operations that include maintaining Saint Elizabeth's Hospital, operating the 24/7 Access Helpline, and the comprehensive psychiatric program. They maintain a methadone distribution system for use in an emergency until an individual can get to a licensed clinic (contracted service that has access to pre-dosages).

DBH provides Staff training and technical support. There is also a certification training program available to ensure continual training and education of staff. Some of the training is open to the community where licenses are not required to participate. Additionally, there are cross-training efforts with members of the Human Services Division that service shelters known as PsySTART (Psychological Simple Triage and Rapid Treatment) that assess individuals and develops techniques to track them. The results assist in identifying and allocating appropriate resources. PsySTART does not measure symptoms. It measures the actual traumatic experience i.e. did the person suffer, die, or witness a lot of blood. These types of occurrences will most likely need follow-up with behavioral health services.

There is also an initiative underway – *anticipate, plan and deter* – which is designed to train individuals to handle stress and prepare for traumatic exposure, monitor traumatic experiences, and collect data. Because people tend to go to hospitals in cases of emergency, emergency responders, hospital staff, and social workers receive on-going training. To ensure that training and data collection is the same across the board, 9-1-1 operators will soon undergo data collection training and start tracking incoming calls from traumatic events.

Discussion:

- Substance abuse treatments (methadone) is necessary because there is an increase number of individuals who come into shelters under the influence of some type of mind-altering drug, making it difficult for clinicians to determine the mental state of a patient or ascertain when another traumatic event might occur. In cases of trauma, healthcare providers understand that people tend to fall back on what they know to ease the pain or they simply avoid facing pain; and as a result, the patient often chooses to increase substance use as an aversion, or sometimes enter shelters to get help while going through withdrawals. It is because of this kind of scenario, that the Behavioral Health Division merged with the Substance Abuse Intervention Program and is now responsible for treating both populations.
- There are 120-trained certified individuals in the District of Columbia with a mobile crisis service that responds to psychiatric emergencies in the city, and when these responders become overwhelmed, they rely on backup from behavioral health. They have three teams that work three shifts per day.
- The Behavioral Health Division recently met with members of the Secret Service resulting in an agreement to provide training to Secret Service who *interface with the public*. They are teaching them better ways to communicate, empathize with survivors, and evaluate victims to detect signs for mental illness or potential threats of violence. Requests from providing agencies for behavioral health service training is on the rise. Everyone should know what to do in cases of emergency.

4. VIRGINIA MENTAL HEALTH INITIATIVES: PRINCE WILLIAM PERSPECTIVE

Courtney S. Tierney, Prince William County

Chairman Tejada noted that at the beginning of the year the committee requested that members take a more active leadership role on priority areas identified in the 2015 Annual Work Plan for the Committee. To that end, he extended thanks to Ms. Tierney for her very active participation on the Human Services and Public Safety Policy Committee.

Ms. Tierney began by first thanking the Community Service Director in Prince William County for preparing the presentation and handouts for this meeting. The Department of Social Services, which falls under the Mental Health Division, provide services surrounding emergency/crisis intervention, intellectual disability, mental health, substance abuse, youth mental health and substance abuse, medical/psychiatric services and early intervention for infants/toddlers with developmental delays. The number of individuals who need and receive care has increased over the past year and next years' Prince William County budget estimate is close to \$40M, which is far less than many of the other jurisdictions. In order to provide quality service, multiple partners are requested to help subsidize funding, particularly in the area of mental illnesses.

Appropriate billing has proven to be a problem. For example, in Virginia, Medicaid is constantly changing, making it more difficult to adequately bill for mental health services (i.e., reimbursement rates, how to process for payment, etc.). Healthcare providers are required to maintain more outcome documentation on patients than before, the process is very time consuming, and this patient population is difficult to follow-up with.

There is a city in the middle of Prince Williams County and the county is responsible for providing services to both Manassas and Manassas Park with very limited inpatient psychiatric facilities and lack of alternative placement for persons who are in crisis, i.e., opioid dependency treatment facility. Most people in need of these types of services are currently overwhelming the emergency rooms and there is only one hospital available in Prince William County with only eight psychiatric beds. The Prince William County continues to attempt to place persons with mental illness in the appropriate facilities and divert them from incarceration. Regardless, there is still a high percentage of individuals jailed with mental illness.

The number of youth under the age of 18 who are in need of mental healthcare is very high with not enough facilities in Prince William County to provide adequate treatment. Currently, Prince William County is using the Commonwealth Center for Children located in Stanton for regional crisis. It is difficult to transport youth such a long distance, and these facility placements removes youth from easy access by their families and a support system. The distance has proven to be too far for families to make routine visits resulting in detachment, and this separation makes it more difficult to integrate youth back to family and community. Temporary detention orders in fiscal year 2015 has increased. Freestanding facilities are limited to what services they can provide and the length of stay is too short to prove positive long-standing outcomes.

There has been recent dialogue with community leaders about considering the community-based option for housing youth and opening youth facilities in the community. The community now understands the need for community-based healthcare as opposed to housing youth in hospitals or detention centers.

Discussion:

- There is increased number of deaths occurring in Prince William County. The county is experiencing an increased suicide rate and there is concern that suicides are becoming an epidemic among the youth. This increase should not be occurring with youth at such an alarming rate.
- When a patient is transported outside of the region (slide 13), it is intended that funding will come from Medicaid or insurance, but ultimately depends on the circumstances. For example, a youths' mental healthcare funding comes from a comprehensive pool of services, which usually covers the cost for residential care. However, taking a youth out of the region for care potentially removes them from residential coverage. If a youth bypasses the system, they will eventually end up in the care of the local government. This has become a financial challenge for the county.

5. OTHER BUSINESS

- Chairman Tejada noted that this is the first meeting since the Latinos and Health Barriers conference was held on October 7, 2015 and requested that Jennifer Schitter give an overview of the conference.
- Ms. Schitter reported that the conference was well attended and she thanked the HSPSPC Committee for spearheading the initiative. MWCOG collaborated with the Regional Primary Care Coalition and George Washington Hospital on the conference and had over 200 participants attend representing health officials, policy experts, community leaders, healthcare workers, and academia. There was a jurisdictional panel with representatives from across the region who came together to identify and discuss the unique challenges and collaborate on public messaging. Participants enthusiastically welcomed Congresswoman Michelle Grisham.
- Mr. Stuart Freudberg extended an invitation for members to attend the December 9, 2015 COG Annual Membership Meeting & Awards Luncheon, celebrating 50 years of the Transportation Planning Board.
- Chairman Tejada announced his resignation as Chair and thanked the committee and MWCOG for allowing him to be of service for the past 13-years. The committee applauded Chairman Tejada for his dedication and service, and wished him well in future endeavors.

6. ADJOURN

With no further business, Chairman Tejada adjourned the meeting at 2:15 PM.

The next meeting will be held February 19, 2016.

Committee documents can be obtained at

http://www.mwcog.org/committee/committee/documents.asp?COMMITTEE_ID=246