BOARD OF DIRECTORS MEETING MINUTES

August 11, 2020

This meeting of the Richmond Behavioral Health Authority (RBHA) Board was held through electronic communication means due to the current State of Emergency and due to safety concerns stemming from the coronavirus pandemic. Board members, staff, and the general public were able to participate by teleconference/videoconference via Zoom.

RBHA Board members present were:; Irvin Dallas, **Vice Chair;** Denise Dickerson, **Secretary/Treasurer**; Dr. Cheryl Ivey Green, **Chair**; Sabrina Gross; Colleen Howarth; Dr. Cynthia Newbille; Melodie Patterson; Malesia "Nikki" Taylor; Eduardo Vidal and Dr. Michelle Whitehurst-Cook.

RBHA Board members absent: Dr. Joy Bressler; Scott Cannady; Karah Gunther; and Chelsea Higgs Wise.

Staff present: Dr. John Lindstrom, **CEO**; Bill Fellows; Dr. Jim May; Shenée McCray; Carolyn Seaman; Michael Tutt; Cristi Zedd and Meleese Evans.

RBHA's Legal Counsel: Jon Joseph of Christian & Barton, LLP.

Guests: None.

The meeting was called to order at 3:07 p.m. by Dr. Cheryl Ivey Green.

Board Chair Report- Dr. Cheryl Ivey Green

- Dr. Cheryl Ivey Green welcomed RBHA's new board member, Colleen Howarth, and asked everyone present on the call to introduce themselves.

Brand Federation Presentation: Kim Baker, Senior Consultant with Brand Federation, presented and discussed the implementation plan for Richmond Behavioral Health's brand strategy. The following RBH Foundation Board of Trustees were present on the call during this presentation: Mary Jane Zacharias Ganey, Peter Buckley and Jen Kostyniuk. Tom Maness, member of the RBH Foundation Development and Communications Committee, was also present during the presentation. The following members of the working group team were present on the call during the presentation: Carolyn Seaman, Theo Appiah-Acheampong, Sheena Garner and Whitney Maxey.

Motion: Irvin Dallas motioned that the RBHA Board of Directors endorse the Brand Federation presentation as presented with funding support as available, seconded by Denise Dickerson and unanimously approved.

Proceedings:

- The Board minutes for July 7, 2020 were approved as amended, to remove committee meeting dates included with the reports, with a motion by Denise Dickerson and seconded by Eduardo Vidal. The minutes were unanimously approved.
- **Public Comment**: None.

Chief Executive Officer's Report- Dr. John Lindstrom

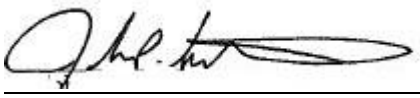
- The CEO report was discussed and is included in today's board meeting packet and with today's meeting minutes.

The meeting adjourned at 5:11 p.m.

The next Board of Director's meeting will take place on **Tuesday, September 1, 2020 at 3:00 p.m. by teleconference/videoconference via Zoom.**

Respectfully Submitted:

Dr. Cheryl Ivey Green
RBHA Board Chair



Dr. John P. Lindstrom
Chief Executive Officer

Richmond Behavioral Health Authority
Board of Directors
Chief Executive Officer's Report
August 11, 2020

In opening this report, I first wish to welcome our newest member of the RBHA Board of Directors. Colleen Howarth was appointed by City Council at its July meeting, taking the seat previously held by Tom Bannard who recently stepped down after completing his term. Ms. Howarth holds a Master's degree in Public Health with a focus on prevention and behavioral intervention. She works as an education and prevention coordinator with Virginia ABC.

Current Operating Status

RBHA continues to employ service modifications undertaken early during the COVID 19 pandemic. Our offices are operating by appointment and all individuals entering RBHA facilities are screened for temperature and other symptoms associated with COVID 19. Face-to-face service delivery is limited to crisis, homeless/housing, PACT, residential, and medical services.

Most case management and outpatient activities are being conducted through telephone or telehealth platforms. Most staff not directly involved in face-to-face contact are engaged in telework for the majority of time. We are exploring additional technology that might be helpful in further streamlining administrative processes and document management.

Positivity rate in the metro area is being monitored closely, along with testing capacity, as both will be key in making any decisions about reopening greater capacity in our residential treatment programs. We are investigating options for reopening face-to-face psychosocial rehabilitation and therapeutic day treatment programs. Since Richmond Public Schools will be virtual this fall, we are exploring location options for delivering TDT services. Service and administrative leadership are working on overall strategies to meet Department of Labor guidelines for workplace standards.

Notice of New or Ongoing Awards

CARE grant from SAMHSA funded for a 3rd year at $524,000 (10/1/20-9/30/21) funds residential SUD services for pregnant/postpartum women.

Suicide Prevention grant from SAMHSA funded for 16 months at $800,000 (7/31/20-11/30/21) funds a combination of care coordination, enhanced intake, prevention and domestic violence services.

Emergency COVID funding from DBHDS funded for 12 months at $140,000 (8/1/20-6/30/21) funds OP and MAT services for uninsured/underinsured SMI population.

Behavioral Health Docket funding from DBHDS funded for 2 years at $196,000 (7/1/20-6/30/22) funds 1.5 FTE case managers for the General District MH Docket (1 CM) and the Circuit Court BH Docket (.5 CM).

Staffing Challenges

Vacancies, illness, and annual leave collectively present challenges in meeting staffing requirements, particularly in residential programs. To date only one program has had to suspend admissions as a result. In consultation with DBHDS, operations at the Children's Crisis Therapeutic Home have been temporarily suspended, allowing staff to be diverted to the Adult CTH and Adult Transition Home.

DMAS and Service Modifications

We continue to follow DMAS announcements as to the extension of telephonic and telehealth services. The waiver of Face-to-Face case management requirements, and the extension of flexibilities pertaining to telehealth, are key to any decision-making pertaining to further large-scale service adjustments at this time.

Facilities

The renovation of the Children's Service Center at the North Campus is nearly complete. The facility is really taking shape and will be a functional and attractive place to provide childminding and early intervention services. Substantial completing is scheduled for this week and I expect full completion by the end of the month.

Chelsea Hill (former Juvenile Courts Building) primarily houses Substance Use outpatient services and a home for SAARA. The facility is leased from Pilgrim Baptist Church. We are closely following the status of this site as PBC has recently leased a large portion of the property to VCU for parking lot construction. PBC has inquired as to RBHA's long-term interests. Options for the Chelsea Hill site are under consideration.

The 420 Cary Street building project will proceed, though the timelines for moving administrative departments are on hold due to COVID 19. Only two building improvements are yet to be completed: interior painting and relocation of existing workstations.

PPE

We continue to update our stores of PPE twice each week. N95 masks continue to be the most difficult to acquire. Our use of N95 masks is fortunately limited to medical procedures and care of symptomatic and COVID positive individuals.

RBHA received 49,000 cloth masks from Health and Human Services. The masks are being widely distributed to all staff and will be given to individuals served.

Equity

A charter for RBHA's Equity Council has been drafted, along with a process for selecting representative staff to sit on the council. The Equity Council will report its findings pertaining to both service and employment equity, along with recommendations, to the Executive Leadership Team.

Crisis Response and Public Safety Reform

The Mayor's task force on Public Safety Reform is moving forward. Several city agency leads are serving in a support role to the task force. RBHA is included in this role.

A separate workgroup is reviewing the intersect between law enforcement and mental health crises. Models for establishing improvements/enhancements in the crisis response system are under consideration. The Marcus David Peters family has requested that improvements, including restrictions around the role and posture of law enforcement, be undertaken under a Marcus Alert program. We are currently reviewing several crisis response models used in other cities as to possible applicability in Richmond. These include co-responder models where police and mental health clinicians are paired.

State Hospitals and Operating Challenges

A recent article from the Richmond Times Dispatch immediately follows this report. Bed shortages or admission obstacles at both local and state hospitals has been an ongoing issue, but made worse under COVID 19. There is no solution immediately available. The situation is further straining resources of our own crisis staff, law enforcement (custody and transfer of custody), and all other parties with involvement in service provision and the civil process.

Federal Aid to Local Governments

A second article from the RTD is also attached detailing relief funds for local governments. Following the article is a statement from VACSB, advocating the CSBs should be considered in distributing these funds. A list of talking points has been crafted, making a strong argument for relief to CSBs. RBHA has inquired as to City plans and will follow-up with further advocacy based on this framework.

VACSB Virtual Public Policy Conference – October 7 & 8

Registration is now open. Conference dates are October 7 and 8. All presentations will remain open for two weeks post conference for flexible viewing. See Meleese for registration information.

Staff Survey on COVID 19 Operations

An agency-wide survey is underway intended to gain an understanding of staff issues related to health, family needs, and work conditions. Results will be used in considering further adjustments to our operations while maintaining maximum flexibility and support of staff. As of this morning, 422 completed surveys have been received, already a strong representative sample of staff. The survey will close at 5:00 PM, August 12. The board will receive a summary of survey results.

Respectfully submitted,

John P. Lindstrom, Ph.D., LCP
Chief Executive Officer

'The house is on fire': COVID makes crowding worse for geriatric patients at state mental hospitals

Virginia has temporarily stopped admissions to two state mental hospitals, as a series of COVID-19 outbreaks has intensified pressure on overcrowded behavioral health institutions.

Piedmont Geriatric Hospital stopped admissions more than two weeks ago after a COVID-19 outbreak that has killed five patients, infected 24 others and sickened nine employees at the state hospital in Burkeville, 55 miles southwest of Richmond in Nottoway County. Six of the infected patients are receiving medical care in private hospitals.

State behavioral health Commissioner Alison Land halted admissions at Southern Virginia Mental Health Institute in Danville on Wednesday, days after alerting Virginia legislators of an escalating crisis in state mental institutions that reached their full capacity at the end of last week and are scrambling to find private institutions and community programs to accept patients.

"With the increase in state hospital census, it is very difficult to maintain bed availability while addressing the infection control, staffing concerns, and isolation protocols to prevent an outbreak within our congregate settings," Land and Secretary of Health and Human Resources Dan Carey said in a letter to General Assembly members on July 23.

The state hospital in Danville has confirmed COVID-19 cases among four staff members and seven patients, including one recovering in a private hospital. However, the interconnected, communal layout of the hospital's three units has forced the state to quarantine the entire facility until the Virginia Department of Health tests all staff and patients.

"It makes it very difficult, without doing some facility-wide testing, to determine who may be exposed and who may be asymptomatic," said Angela Harvell, deputy commissioner for facility services at the Department of Behavioral Health and Developmental Services.

Statewide, 92 patients and employees at Virginia's behavioral health institutions have tested positive for COVID-19, with almost 300 test results still pending. The only deaths have occurred at Piedmont, but the state is coping with outbreaks at Eastern State Hospital near Williamsburg, where 16 employees and six patients have tested positive, and Southeastern Virginia Training Center in Chesapeake, where three employees and five patients also have tested positive for the disease.

Western State Hospital in Staunton has one patient and two employees who tested positive for COVID-19. Five other state institutions have confirmed COVID-19 infections among staff, but not patients — Central State Hospital near Petersburg, four; Catawba Hospital near Salem, four; Northern Virginia Mental Health Institute in Falls Church, four; Central Virginia Training Center in Lynchburg, one; and the Virginia Center for Behavioral Rehabilitation, next to Piedmont in Burkeville, with three.

The only state institutions with no confirmed cases of COVID-19 are Hiram Davis Medical Center next to Central State in Dinwiddie County; Southwest Virginia Mental Health Institute in Marion; and the Commonwealth Center for Children and Adolescents in Staunton, the state's only psychiatric hospital for children.

Lull, then overload

The crisis began in Virginia's behavioral health institutions after a lull in admissions turned into an overload beginning in mid-June.

Land and Carey said the patient census at the state's seven mental hospitals for adults had been stable or declining early in the coronavirus public health emergency that began in early March, but the situation worsened rapidly as Virginia began to loosen restrictions the state had imposed on business and public life to control the spread of COVID-19.

"As communities began to reopen, state hospitals experienced rapidly increasing census levels and are currently at critical levels with utilization at or above maximum capacity statewide," they said in the letter.

The crisis is worst in geriatric hospitals for elderly patients with psychiatric issues, who are hard to place in private psychiatric facilities or nursing homes that have been at the epicenter of the COVID-19 pandemic in Virginia. Piedmont had been operating above its capacity before the outbreak began, but now has 92% of its beds occupied.

“That is where the real problem is,” said Sen. Frank Ruff, R-Mecklenburg, whose district includes Piedmont, as well as two nursing homes in Mecklenburg County that have had 176 COVID-19 cases and 27 deaths between them.

“It’s regrettable, but I don’t know there is any real solution,” Ruff said Wednesday.

Geriatric units were operating Wednesday at 115% of capacity at Eastern State; 110% at Southwest Virginia Mental Health Institute; and 105% at Catawba. Systemwide, Virginia’s mental hospitals were operating at 98% of their capacity on Wednesday, with both Central State and Western State at or slightly above 100%.

State legislators have been trying to reduce reliance on state institutions for emergency psychiatric care, but the system already was overloaded before the coronavirus crisis.

The assembly included money in the two-year state budget to help relieve the pressure on state institutions, but those investments were suspended in April because of concerns about a shortfall in predicted tax revenues to pay for increased spending.

‘Put the fire out’

“The house is on fire,” said Sen. Creigh Deeds, D-Bath, the leader of a bipartisan legislative commission to make long-term changes in Virginia’s behavioral health system. “We’ve got to figure out how to put the fire out and move forward.”

Deeds said he remains focused on spending less money on institutions and more on community-based programs to keep people out of institutional care, but the assembly will face difficult choices when it convenes next month to revise the budget to match spending with potentially $2 billion less in revenues that had been forecast for this year and next year.

Suspended budget initiatives include almost $50 million to expand mental health services in communities, more than $25 million to pay for supportive housing for people with behavioral health problems, $20 million to discharge patients from institutions when they no longer clinically need to be there, and $15 million to reduce the daily census at state institutions.

“That’s something I think should be a priority,” said Sen. Emmett Hanger, R-Augusta, who chairs the Senate Finance health and human resources subcommittee.

State officials previously have blamed the problem partly on an increasing reluctance of private psychiatric facilities to accept more patients under temporary detention orders.

Private psychiatric hospitals also are scrambling to contain the spread of COVID-19 in their facilities, forcing them to operate with fewer beds and leaving Virginia with fewer options as it responds to coronavirus outbreaks at state institutions.

"We're the only room at the inn," said Land, a former private hospital official whom Gov. Ralph Northam appointed commissioner last year after Commissioner Hughes Melton died from injuries in a traffic accident.

As a result of the state diverting admissions from stricken hospitals, 17 people in psychiatric crisis are waiting — primarily in private hospital emergency rooms — for placement in beds for treatment after being found a threat to themselves or others, or unable to care for themselves.

"They have to go somewhere," Land said.

Richmond Times Dispatch

Virginia to send $644.6 million in federal aid to local governments in second round of relief

With Congress preparing to debate relaxing restrictions on emergency aid to state and local governments, Gov. Ralph Northam is sending almost $645 million in federal funds to localities to help them weather the coronavirus crisis and its economic repercussions.

The money is the second half of the $1.3 billion in federal aid under the CARES Act that Virginia is allocating for local governments to use under current rules that limit spending to expenses directly related to combating the spread of COVID-19. The state distributed $644.6 million to localities in early June, based on population.

Together, the allocations represent 45% of the $3.1 billion that Virginia received from the federal government last spring with the recommendation that it use at least 15% of the money to help localities. Only Fairfax County, with more than 1 million people, received a $200 million payment directly from the federal government under the CARES Act.

"We are giving them almost *half* of Virginia's entire allocation," Northam said Tuesday. "That's a big deal."

However, the governor also challenged local governments "to step up" and use their share of the money to help entities within their borders to cope with the COVID-19 emergency.

"This money will help them do the things that we all want to see — from rent assistance and eviction protection, to food security, to [personal protective equipment], and tools to help educate children," he said.

Northam said the state will require localities to be accountable for how they spend money "to make sure this gets done the right way."

Congress is girding for negotiations over a new stimulus relief package that, at a minimum, appears likely to give state and local governments some of the flexibility they have sought to use the money to compensate for lost tax revenues, including taxes on sales, meals and lodging, and event admissions that local governments rely upon to reduce pressure on property taxes.

"We have been begging them for flexibility, so that's good," Senate Finance and Appropriations Chairwoman Janet Howell, D-Fairfax, said Tuesday. "But we also have to have more money."

“They are just not being realistic about the needs of the people of this country,” Howell said.

The $1 trillion HEALS Act that Republican leaders in the U.S. Senate introduced on Monday does not include any additional money for state and local governments, only loosened rules for using the $150 billion reserved for them in the CARES Act. In contrast, Democrats in the House of Representatives included an additional $1 trillion for state and local governments in the HEROES Act adopted more than two months ago, or about one-third of the $3 trillion legislative package.

Virginia has obligated about $500 million of the $1.8 billion in federal aid it received under the CARES Act for its expenses in dealing with the coronavirus pandemic, primarily for COVID-19 testing and contract tracing of positive cases, as well as protective gear for health care and public safety workers and a Medicaid stipend for nursing homes to use to pay staff.

The state also has used about $91 million of the federal money to pay additional expenses of state agencies in dealing with the health and economic crises. Northam also has reserved $50 million for mortgage and rental housing relief and $70 million for a new grant program for small businesses that he announced on Monday.

State officials say local governments have borne the brunt of a sharp decline in consumer spending that has reduced sales tax revenues, as well as tax revenue from food and beverages, lodgings and admissions that has disappeared because of the near shutdown of the state’s hospitality industry.

“What I’m hearing from local governments is they’re desperate for the money and they feel that doing it on population is a fair way to go,” Howell said.

Secretary of Finance Aubrey Layne said the state’s decision to allocate the money based on population will help all localities, especially if Congress loosens the rules on how they can spend it.

However, the state will require local governments to certify that they will abide by federal restrictions on how the money can be used, and complete an online survey to report how they have spent the money distributed to them last month and how they plan to use funds in the second round.

Localities will have until Aug. 10 to complete the certification and survey, and the state will send the money within five business days of receiving the information.

“The whole idea is to be accountable,” Layne said. “It’s also to use the money in the best way.”

House Appropriations Chairman Luke Torian, D-Prince William, said the distribution of money to localities “is going to be very helpful.”

Torian said Congress also can help state and local governments as it considers the next emergency relief package.

“I’m not sure if they are going to provide us more new resources,” he said. “If not, I hope they provide us some flexibility.”

Talking Points for Use in Requesting CARES Act Funding Distributed to Local Governments from the State

CARES Act Funding will be Essential to Sustaining your Public Safety Net

Each CSB received funding from the first round of relief from the CARES Act based on a percentage of their Medicare reimbursements. Initially, CMS stated that organizations that received the Medicare-based patient care revenues were not eligible to receive any funds based on their Medicaid revenues. While CMS has since reversed that rule, stating that providers are eligible to receive funding from both tranches, CSBs are still struggling financially due to lost revenues. CSBs have instituted a myriad of changes to their operations in order to stay fiscally sound, but in some instances that has meant laying off or furloughing staff. CSBs, as public safety net providers, need special consideration so that they can remain robust and available throughout the pandemic and beyond.

YOUR CSB NEEDS ACCESS TO THE $645M IN FEDERAL AID TO LOCAL GOVERNMENTS THAT WAS RECENTLY ANNOUNCED

CBS are innovative, efficient and react to the needs of their communities. As such, they have continued to meet their code mandated service requirements throughout the pandemic, despite a financial loss, staffing shortages and other unexpected burdens due to COVID-19.

Reasons why CSBs Need Funding from their Localities

1. **Telehealth Infrastructure Costs Money** – CSBs have incurred costs in the transition of services to telehealth. Costs are associated with hardware and software as well as licenses and upgrades to existing systems.
2. **Working from Home** – CSBs have incurred costs to make it possible for CSB employees to work from home. Costs are associated with hardware and software as well as infrastructure for those working remotely to collaborate with one another.
3. **Therapeutic Day Treatment** – CSBs lost revenue when schools closed in the spring and will continue to do so as most of the larger school districts will begin their school year with remote learning. The Medicaid MCOs were disallowing TDT at a higher rate before the pandemic which was making it difficult for CSBs to sustain programs, but now many have had to close permanently. For some children, TDT is the only service available to them to support them in the learning environment.

4. **Group Day Support & Community Engagement for Individuals with DD** – CSBs were unable to provide this service due to social distancing requirements and in-person limits. Provider retainer payments have helped, but they came late in the game and are no longer available, and some programs had to lay off staff or close prior to that relief being made available. Those programs cannot access the retainer payments and will need general fund dollars to allow them to re-open or to continue to provide services now that the retainer payments have ended.
5. **PPE Purchases -** CSBs have had to purchase PPE both for their staff and for individuals who may be seen in a face-to-face setting. Close clinical engagement for services such as PACT and medication administration/management require full PPE, not just a face covering. In addition, CSB staff spend copious time searching for PPE and end up paying a premium because PPE is again becoming difficult to obtain. While there is a mechanism for reimbursement for PPE through the state, it only covers purchases through the end of December and we anticipate a need beyond that.
6. **Residential Capacity** – CSBs had to reduce residential capacity in order to adhere to social distancing requirements within their facilities. This means a loss in revenue in one of the most expensive services that CSBs deliver. In addition, residential services are extremely vulnerable settings for the spread of the virus, so testing is another expense.
7. **No Additional Per Diem** - There has not been a move to provide an additional per diem to CSBs that operate 24/7 residential services such as what was done for the nursing homes and what is being pursued for the auxiliary grant rate to support the assisted living facility to take on Medicaid patients.
8. **Need More Flexibility in General Funds** – There is currently not enough flexibility in how CSBs can use state general fund dollars to allow them to "even out" their cash flow between and among services. CSBs need access to unrestricted general fund dollars in order to make sound fiscal and business decisions.