REPORT OF THE
OFFICE OF THE INSPECTOR GENERAL
FOR THE DEPARTMENT OF MENTAL HEALTH, MENTAL
RETARDATION AND SUBSTANCE ABUSE SERVICES

Semi-Annual Report

(April 1 - September 30, 2001)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 16

COMMONWEALTH OF VIRGINIA
RICHMOND
2002

Table of Contents

COMMONWEALTH of VIRGINIA

Office of the Governor

James S. Gilmore, III
Governor

Claude A. Allen
Secretary of Health and Human Resources

Anita S. Everett
Inspector General
Department of Mental Health, Mental Retardation and Substance Abuse Services

Dear Stakeholder,

Every Virginian has a stake in the publicly funded mental health, mental retardation and substance abuse services system. The involvement ranges from participation in services to the payment of local, state and federal taxes that support the system. This system of publicly funded institutional and community services has a budget of over 1 billion dollars. In 2000, Virginia served 295,227 people through community services and 3300 people in mental health or mental retardation institutions in Virginia. Forty two percent of the total budget supports infrastructure for institutional care with the remaining fifty eight percent being used for community services and central office management.

The challenge of providing adequate services with limited public resources is not unique to Virginia. The 2000 Report of the Surgeon General on Mental Health emphasizes the extent to which mental disabilities are present in our society. For example 22% of American adults have a current diagnosable mental illness. About 20% of children in America are estimated in this report to have a diagnosable mental disorder causing more than mild functional impairment. The costs for mental illness are calculated in two forms, these are direct and indirect costs. Direct cost considerations include the funding of treatment and rehabilitation; indirect costs include loss of productivity in workplace, home and school. As Surgeon General Satcher states: "few families in the United States are untouched by mental illness."

In 1999, the Office of Inspector General (OIG) to DMHMRSAS was established to increase accountability within the state operated facilities. The OIG was established following federal government investigations of five of the fifteen state operated facilities in Virginia. In association with these investigations, the Department of Justice alleged that Virginia was violating the constitutional rights of institutionalized individuals through providing care that was lacking in terms of quality, availability, and even basic safety. It is the mission of the OIG to challenge the system to provide quality services that are consistent with contemporary clinical guidelines.

This is the first 6-month report required by legislation enacted in the 2001 session of the General Assembly. This report replaces the previously required annual report.

It is the intent of this report to account for the activities of the OIG as well as to provide a summary as to the inspection findings and recommendations made by the OIG within the six-month reporting period from April 1, 2001 to September 30, 2001.

P.O. Box 1475 • Richmond, Virginia 23218 • (804) 786-7765 • TDD (804) 786-7765

The first four chapters of this report provide information regarding the activities and functioning of the OIG. In addition to the usual inspection and reporting activity conducted by the OIG, a major undertaking of this office in the last six months has been the development of a follow up and tracking system. Through this process the OIG has evaluated progress made toward each of the 418 findings made since the first Inspector General report in 1999. Chapter 5 provides a summary as to the actual findings made within the institutions during inspections over the last six months. Staffing within Training Centers has been a focus of OIG inspections during this period. Chapter 6 provides information regarding the immediate future plans of the office.

Many families in Virginia are touched by mental health, mental retardation and substance abuse issues. We are all stakeholders. The OIG plays a unique role in providing accountability to stakeholders. This semi-annual report is reflective of the terms of accountability of the OIG and provides summary information from inspections and reports completed within the 6-month reporting period of this report.

Sincerely,

Anita S. Everett, M.D.
Inspector General

Chapter 1: Introduction

At the outset of his term Governor James S. Gilmore III fulfilled an administrative priority through the establishment of the Office of the Inspector General (OIG). One key element for government in maintaining the public trust is through the development of systems of accountability. Over the last 12 years the operations of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has undergone scrutiny by the federal government through Department of Justice investigations. This ongoing scrutiny has resulted in an erosion in the public confidence of the state's ability to provide effective services. The Office of the Inspector General was designed to promote and advance accountability and integrity in the quality of clinical services as delivered by DMHMRSAS through the development of an inspection process that is objective, professional, independent, fair and forthright.

This new office was designed to be external to the operations of the DMHMRSAS and provide an unprecedented degree of accountability. The creation of the OIG in Virginia proved to be nationally significant; no other state has this level of scrutiny in the form of an independent Inspector General position for clinical services within the mental health delivery system. Inspectors General are granted substantial authority in order to execute the duties of their Office as established by statute. It is critical that any Inspector General regard the office as a public trust and its primary responsibility as serving the public interest.

It is the essential function of this office to provide an enduring challenge to the quality of clinical care in the facility system in Virginia. In order to incorporate contemporary clinical ideas, the OIG actively participates in statewide and nationally recognized meetings and conferences. These meetings provide valuable information and opportunities for exchange of ideas and exposure to successful programs developed in other state systems and countries.

Within the first year of appointment, Dr. Anita Everett, the Inspector General received certification from the American Association of Inspectors General. The intensive training required to receive this certification expanded the knowledge of current trends in inspections, investigations, and audit practices. In addition the Inspector General is an active member of national associations, such as the American Psychiatric Association, American Association of Community Psychiatrists, American Association of Inspectors General, Psychiatric Society of Virginia, and Virginia Association of Community Psychiatry. This provides the Inspector General with an opportunity to exchange information regarding the delivery of quality services that are consistent with contemporary clinical guidelines.

History of Changes in the Code

In January 1999, the position of Inspector General was established in order to provide independent clinical consultation to the Governor regarding the quality of care provided in the statewide mental health, mental retardation facility system. As the position demonstrated value and necessity, bipartisan support from legislators during the 2000 General Assembly session was received. The Office was permanently codified pursuant to chapter 927 of the 2000 Acts of

the Assembly. Delegate Robert Bloxom was the chief patron to HB 1034,which was the legislation that created the Office of the Inspector General. This legislation, HB1034, provided the office the authority:

1. *To provide oversight and conduct announced and unannounced inspections of the facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services on an ongoing basis, in response to specific complaints of abuse, neglect, or inadequate care, and as a result of monitoring of serious-incident reports and reports of abuse, neglect, or inadequate care or other information received, and to make recommendations to the Governor, the Secretary of Health and Human Resources and the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services on methods to improve the quality of care in such facilities.*
2. *To access any and all information related to the delivery of services, including confidential patient or resident information, to patients or residents in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Such patient or resident information shall be maintained by the Office of the Inspector General as confidential in the same manner as is required by the state agency from which the information was obtained.*
3. *To monitor any reports prepared by the Department of Mental Health, Mental Retardation and Substance Abuse Services and critical incident data collected by the Department of Mental Health, Mental Retardation and Substance Abuse Services in accordance with regulations promulgated under §37.1-84.1 to identify issues related to quality of care seclusion and restraint, medication usage, abuse and neglect, staff recruitment and training, and other systemic issues.*
4. *To monitor and participate in the promulgation of regulations by the State Mental Health, Mental Retardation and Substance Abuse Services Board.*
5. *To receive reports, information and complaints from the Department for the Rights of Virginians with Disabilities concerning issues related to quality of care and to conduct independent reviews and investigations. (2000, c. 927.)*

The transition in 2000 from "pilot project" to "permanent codification" demonstrated that the Office, under the leadership of Dr. Everett, was fulfilling the Vision and Mission established and was recognized by elected members of Virginia government as a valuable asset to the Virginia facility system.

During the 2001General Assembly session, confidence by Virginia lawmakers was demonstrated even further with the expansion of powers and duties for the Office. With the codification of HB1653, the OIG was granted the additional authority to:

conduct such additional investigations and make such reports relating to the administration of the programs and services of the facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services and providers as defined in § 37.1-179 as are, in the judgment of the Inspector General, necessary or desirable.

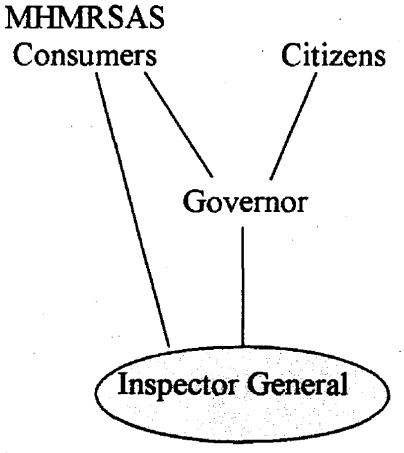
Additionally the following requirement was added:

conduct unannounced inspections at each state facility at least once annually

These additional powers and duties established the authority and ability for review of the quality of care within any program licensed by DMHMRSAS. The staff and funding resources remained the same while additional mandates were added regarding the completion of an inspection at each facility each year. Therefore the OIG has not been able to take advantage of the opportunity created by this legislation.

Current Status of Office

The current accountability structure for the Office of the Inspector General appears as such:



§2.1-816 provides the Inspector General the authority to operate and manage the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services and to employ such personnel as may be required to carry out the provisions of this chapter.

Though the scope of the office as been enlarged over the last three General Assembly sessions, the office structure has only been funded for the Inspector General and two additional employees. From the onset the Inspector General firmly believed that this Office could be both productive and effective through the creative integration of technology with a small core of professional, dedicated and motivated staff. Staff are selected to provide a combination of clinical and operational expertise through prior experience in both private and publicly funded systems of care. The office structure is headed by the Inspector General and supported by two permanent staff members, the Director of Inspections Cathy Hill, and the Operations Manager, Heather Glissman.

The **Director of Inspections** is responsible for the following: to coordinate and manage all announced and unannounced inspections to mental health/mental retardation facilities; coordinate and manage the use of all professional and consumer consultants contracted to facilitate inspections and/or investigations; work cooperatively with the Inspector General to complete all reports related to inspections and or investigations as well as responses to Plans of Correction submitted by the Department of Mental Health, Mental Retardation and Substance Abuse Services; operate in the place of the Inspector General at events the Inspector General is unable to attend; operate jointly with the Inspector General or the Operations Manager on special projects conducted by the Office of the Inspector General; attend weekly and monthly planning meetings.

The **Operations Manager** is responsible for all production aspects of the Office of the Inspector General. This includes: management of special projects conducted by OIG staff; management of inspection and report completion; press and public relations coordination; monitoring Critical Incident Reports and investigating further, where required; management of the office budget and scheduling; coordination of office legislation; communication with public and private stakeholders; coordination of weekly and monthly planning meetings; and tracking of all documentation generated by office.

In addition to full time staff, professional and consumer consultants were hired to compliment the expertise offered by the permanent staff. It is a value held by the OIG that consumers could make valuable contributions to the assessment of the quality of services within our state hospitals and facilities.

A **Professional Consultant** has the knowledge, skills and abilities to provide professional expertise for certain aspects of inspections. The Professional Consultant functions as an agent of the Office and engages only in authorized activities.

A **Consumer Consultant** has had experience within the state mental health/mental retardation facility system as a consumer. These consultants accompany OIG staff on inspections and assist with the evaluation of the quality and conditions of care in the DMHMRSAS facility system.

These consumer consultants were chosen based on geographic location, skills and their experience within the mental health system. There were 26 applications of which 7 consumers were chosen. The consumers were trained by OIG staff regarding their responsibilities as consultants to the Office. The information that consumer consultants collect and provide is key to the process of recommendations for improvements to quality care.

With the combination of permanent staff and consultants, the Office was able to: incorporate additional special projects; collaborate on projects between the OIG and other state agencies; increase the ability to review and formally comment on documents that directly effect patient care; and accept more invitations to participate in local and statewide conferences and forums.

Chapter 2: Office Goals

Our Vision is that each consumer of services provided through the delivery system of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is afforded quality care that is individualized, meaningful and provided in a safe and effective manner improving their basic quality of life.

The Mission of the Office of the Inspector General is to challenge the mental health, mental retardation and substance abuse system to provide quality services for Virginians that are consistent with contemporary clinical guidelines and contemporary financial management strategies.

According to guidelines established by the Association of Inspectors General, "each OIG must have a strategic plan that details its vision and mission, goals, objectives and strategies against which it expects to be held accountable."

The OIG has developed a strategic plan, which was incorporated in the Governor's statewide strategic plan. The plan as constructed by this office, provided the framework for the development of realistic goals and measurable objectives and has served as the building blocks for the establishment of the vision, mission, and annual goals. During the 2001 calendar year, ten goals were developed as the working links to our vision, mission and strategic plan.

The following is a synopsis of the accomplishments related to the established 2001 annual goals.

Goal #1: There will be one inspection completed at each facility within 2001

One inspection was completed at each facility by September 11, 2001. Since January 2001, 27 regular and follow-up inspections have been completed. Twenty-two of these inspections occurred during this semi-annual reporting period of April 1 – Sept. 30, 2001.

Goal #2: Enhance the number of Snapshot Inspections completed

Seven snapshot inspections have been completed. These occurred at Northern Virginia Mental Health Institute in Fairfax, Virginia; Hiram W. Davis Medical Center in Petersburg, Virginia; Southwestern Virginia Mental Health Institute in Marion, Virginia; Southern Virginia Mental Health Institute in Danville, Virginia; Piedmont Geriatric Hospital in Burkeville, Virginia; Catawba Hospital in Catawba, Virginia, and Eastern State Hospital in Williamsburg, Virginia. Six these were completed within the semi-annual reporting period. By comparison, four snapshot inspections were completed in 2000. Additionally, the Snapshot inspections were enhanced in quality by adding structured staff and consumer interviews.

Goal #3: Increase the use of consumer consultants

During this year, the Office increased the involvement of consumers primarily through increased involvement with snapshot inspections. Additionally a consumer was hired as a contractor to assist the Richmond office with clerical functions. One of the consumer consultants represented the OIG at a national conference dedicated to issues associated with the employment of persons with mental illness in Washington D.C. in October 2001.

Goal #4: Enhance follow-up

A two-tiered procedure for monitoring the implementation of plans of correction created by DMHMRSAS in response to OIG recommendations was instituted May 1, 2001. The first tier consists of the completion of onsite follow-up visits. Compliance with the plan of correction is verified through several methods, including observations, interviews and a review of documents during each follow-up visit. The second tier requires that semi annual update progress reports be submitted by DMHMRSAS on January 30 and July 30 of each year. Each finding for every OIG report is monitored until satisfactorily resolved.

Goal #5: Enhance the tracking of OIG activities

A number of mechanisms were executed in order to accomplish this goal. Among these were the establishment of seven databases that track details relating to: site visits; the status of reports including plans of correction; website postings; active and inactive findings; participation in conference and meetings; numbers of Departmental Instructions reviewed; correspondence addressing a concern and/or providing information to federal and state government officials and Virginia citizens; and presentations by the OIG. Summaries of the tracking activities are outlined during monthly planning meetings.

Goal #6: Increased periodic attendance at ongoing meetings of significance to the functions of the Office of the Inspector General

The OIG has increased attendance at ongoing meetings. Among these are:
Facility Directors' Quarterly Meeting; Medical Directors' Quarterly Meeting; Mental Health Quality Council; Rural Mental Health Association; American Psychiatric Association Conferences; American Association of Community Psychiatrists; Psychiatric Society of Virginia; Virginia Association of Community Services Boards; Virginia Association of Community Psychiatrists; DMHMRSAS Board; and DMHMRSAS facility sponsored mental health conferences; Mental Health Planning Council; and the Virginia Alliance for the Mentally Ill quarterly board meeting.

Goal #7: Promote opportunities for the general public, professionals and consumers in Virginia to become familiar with the work of the Office of the Inspector General

The Office was created to promote an increased accountability and accessibility to the general public about the quality of care provided in DMHMRSAS facilities. Accessibility is defined as a term that donates: ease of use, openness, and user friendliness.

These terms accurately define goal #7. Among the activities that demonstrate this accessibility, were presentations, recreation of the website and correspondence. Sixteen presentations were completed, 9 of which occurred during the reporting period. The recreation of the OIG website, a priority project, (www.oig.state.va.us) was completed June 30, 2001. The new website currently posts 31 reports and has been visited over 600 times. Additional public accountability was provided through the completion of 38 pieces of correspondence (33 during the reporting period), which addressed a concern and or provided information to federal and state government officials, and Virginia citizens.

Goal #8: Complete two Special Projects within 2001

Special Projects are projects identified by the OIG as issues that have a potential impact on the facility system and/or are of national significance. Special projects may be initiated as a result of a request of another agency. Among the special projects the OIG has originated or participated in this year include:

Death Study – This study reviewed all the deaths that occurred in the facilities during the thirteen-month period from October 1, 1998 to October 31, 1999. A retrospective chart review was completed on 127 patients who died while admitted to a Virginia mental health or mental retardation facility during the thirteen-month study period. The purpose of the review was to study in some depth the clinical circumstances of each of these deaths.

Discharge Study – The Southeastern Rural Mental Health Research Center (SRMHRC) at the University of Virginia under the auspices of the OIG conducted a study of patients discharged from public inpatient psychiatric facilities in Virginia. The study was designed to examine the discharge placement process and outcomes. Results from this study are currently being analyzed by OIG staff in preparation for publication and release.

Psychiatrists in Underserved Areas - Recruiting and training psychiatrists to serve in rural, underserved areas of Virginia is an essential component in the continuance of quality care to patients. This program's goal is to encourage psychiatry residents to pursue community psychiatry as their career choice. This program is administered by Psychiatrists in Underserved Areas Committee (PUAC), whose members include the Inspector General, representatives from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Virginia Department of Health (VDH). As Virginia moves towards a community based placement system, it becomes critical for Virginians to continue to have access to mental health professionals. Research has proven that early exposure to a mentor in any field can have a powerful and positive impact. Due to this, we have incorporated Governor Faculty Fellows to help train and involve psychiatry residents to become involved in this program and thus lead to more community-based psychiatrists practicing in Mental Health Professional Shortage Areas. The program provides for one Faculty Fellow at each of the Psychiatry programs in Virginia, plus three Governor Awardees per program.

ALF Study – OIG staff met with representatives from the Department of Social Services to explore aspects of practices and services available to individuals with mental illness who reside within assisted living facilities (ALF) and to discuss the feasibility of conducting a joint review. There have been technical difficulties pursuing this study because ALF's are licensed by DSS and not DMHMRSAS.

Department of Corrections Study - In April of this year, the Office of the Attorney General requested the services of the OIG to review the mental health services in selected prisons in the Commonwealth.

Chief Medical Examiner proposed Legislation – The "Death Study" conducted by the OIG, provided adequate information and resulted in collaboration between DMHMRSAS and the Chief Medical Examiner regarding possible legislation. This proposed legislation would result in a mandatory Medical Examiner review of all deaths within the state mental health and mental retardation facilities. The OIG facilitated this collaboration and recommended that the Governor support the proposed legislation.

American Association of Community Psychiatrists (AACP) Spring 2003 meeting – The AACP is a national organization that meets semi annually (once in the Spring and once in the Fall) in order to convene Psychiatrists already working or planning to work in the community. These conferences serve as a valuable tool to exchange ideas and methods and to learn from nationally recognized models. The Inspector General is a member of the AACP Board of Directors and has been able to represent the work that Virginia has done within its Mental Health delivery system at these semi-annual conferences. The Inspector General has arranged for the Spring 2003 conference to be held in Virginia and is currently working to organize this event.

University of Virginia (UVA) Psych Ward review – The Inspector General was requested by UVA in August 2001, to review issues related to treatment concerns such as active treatment and the use of seclusion and restraint. This review is currently in process.

Training Center Resource Inequity – In 2001, the OIG concluded a review of staffing patterns within training centers as it relates to quality of care. This review was conducted on-site at all five training centers. The data demonstrated a disproportionate number of staff and resources had been allocated to the Training Centers. The outcome of this review concluded with a Decision Brief prepared by the OIG, Office of the Secretary of Health and Human Resources and the Department Planning and Budget to submit to the Governor for consideration. This resulted in additional resources being allocated to the training centers for staffing.

Jones Institute - In light of stem-cell research activities conducted at the Jones Institute, the Governor asked that the Secretary of Health and Human Resources assemble a team to conduct an study into the research of the Institute. The Inspector General participated as a member of the team.

Goal #9: Enhance monitoring of trends in facility functions and reports, policies and regulations produced by DMHMRSAS

Progress has been made in establishing a mechanism of monitoring DMHMRSAS information. Currently the information monitored includes Critical Incident (CI's) reports from the facilities. To date, 631 CI's have been monitored, 346 of these have occurred within this semi-annual reporting period. Review and comment has been completed for three DMHMRSAS sets of regulations and 16 new Departmental Instructions.

Efforts have been ongoing since March 30, 2001 to obtain additional quantitative facility data each month from DMHMRSAS. The information requested included: facility census data; facility human rights data; facility seclusion and restraint data; facility death data; and facility personnel data. The personnel data would address: position vacancies, new hires and separation from service, broken down by position; a report of facility overtime hours; and a report of staff injuries.

Goal #10: The OIG will conduct four primary inspections during the 2001 calendar year.

This calendar year the OIG has conducted 3 primary inspections with the 4th scheduled for the last quarter.

Chapter 3: Inspections

The mission of the Office of Inspector General is to challenge the DMHMRSAS system to provide quality care that is consistent with contemporary best practices. This is accomplished through a series of announced and unannounced inspections and subsequent reports, which are responded to by DMHMRSAS. The Office of Inspector General works to compliment the usual regulatory processes such as licensure, JCAHO and Center for Medical Services (formerly HCFA, Health Care Financing Administration). Thus the Office of Inspector General is able to continuously challenge the quality of services such that they are reasonably safe, effective, patient centered, timely, efficient and equitable. Ultimately this should result in Virginia being less vulnerable to scrutiny by external entities such as the federal government through the Department of Justice.

Each inspection is accompanied by an Inspection Report, which is written within 30 days. The inspection reports record observations in sets of information that includes findings, background and recommendations. This report is then presented to the Governor's Office and to the Commissioner of DMHMRSAS through the Secretary of Health and Human Resources. A plan of correction is developed within two weeks that includes a response to each recommendation within the Inspection Report. The plan of correction is reviewed by the OIG and is either accepted or returned to DMHMRSAS for revision. Upon acceptance of the POC, the report is considered to be a complete report package.

Compliance with the accepted plan of correction is monitored through periodic onsite follow up visits as well as through progress reports, which are submitted to OIG by DMHMRSAS at six month intervals.

Review of Reports:

Within this semi annual reporting period of April 1 – September 30, there were 15 report packages completed. These reports comprise information obtained during the completion of four primary inspections, seven snapshot inspections and four secondary inspections.

Primary Inspections

Primary inspections are comprehensive visits, which may last three to five days. These inspections are unannounced. The purpose of a primary inspection is to evaluate a broad array of components of the quality of care delivered by the facility and to make recommendations regarding performance improvement. There are currently eight categories for review, within each primary inspection. These eight areas are: treatment with dignity and respect; use of seclusion and restraint; active treatment; environment of care; access to medical care; public/academic relationships; notable administrative projects; and facility challenges.

There were four primary inspection report packages completed during this semi-annual reporting period. These inspections were conducted at Southeastern Virginia Training Center, Southern Virginia Mental Health Institute, Southwestern Virginia Training Center, and Southside Virginia Training Center.

Snapshot Inspections

Snapshot inspections are unannounced visits designed to review the status of each facility at a point in time. Snapshot inspections are typically scheduled during evenings, weekends and holidays. The intent of these inspections is to verify that residents and inpatients in these facilities are receiving active treatment delivered by a reasonable number of staff in a reasonably clean environment. Consumer consultants have proven to be very helpful with this form of inspection through the completion of environmental checks and patient interviews.

There are three areas reviewed, these are: A) the general condition of the facility, B) the activities of the patients and C) the staffing patterns at the time of the inspection and any other identified staff related issues.

There were seven Snapshot Inspection reports completed this reporting period. These were conducted at Northern Virginia Mental Health Institute in Fairfax; Hiram W. Davis Medical Center in Petersburg; Southwestern Virginia Mental Health Institute in Marion; Southern Virginia Mental Health Institute in Danville; Piedmont Geriatric Hospital in Burkeville; Central State Hospital in Petersburg; and Catawba Hospital in Catawba.

Secondary Inspections

Secondary Inspections are inspections performed following the identification of a potentially serious problem, which may represent a pattern of substandard care. These patterns may have a direct and immediate effect on the health, safety, or welfare of patients. The purpose of secondary inspections is to evaluate any potential problems and make recommendations to the program for performance improvement. The content of secondary inspections is uniquely defined by the nature of the critical incident under review.

These inspections often review circumstances of specific residents and patients. It is the intent of the OIG to respect an individual's right to confidentiality as well as the peer review process. Thus, any corresponding reports are not available for public view.

There were four Secondary Inspection reports completed within this reporting period.

Chapter 4: Follow-up Inspections and Compliance Monitoring

During this six-month reporting period, the Office of the Inspector General developed and initiated a follow-up inspection process and a compliance reporting mechanism. Every finding and subsequent recommendation made within an OIG report is responded to by DMHMRSAS and the corresponding facility through a plan of correction (POC). This POC is accepted by the OIG or returned for ongoing refinement until accepted. With a final acceptance, indication is provided to DMHMRSAS regarding which findings will be the subject of ongoing active monitoring. The findings that do not require further monitoring are designated as inactive at this point. All findings are followed until deemed inactive by OIG.

The mechanism through which active findings are monitored includes two tiers. The first is through Follow Up Inspections. This process includes the onsite verification by OIG staff regarding progress toward the agreed upon plan of correction as presented by DMHMRSAS. The second mechanism whereby active findings are monitored is through a progress report made at six-month intervals by the facility through DMHMRSAS to the OIG.

Follow-Up Inspections

Follow-up inspections are the mechanism by which the OIG verifies the progress of a facility toward the compliance with the POC. Follow-up inspections in general are unannounced in order to gain a realistic perspective of the facility's progress. At a follow-up inspection, any active recommendations from previous Inspection reports are reviewed. Evidence is required from two sources in order to recommend that the finding become inactive. The sources may include interviews with staff, patients, review of procedures, memoranda, medical records, or other documents.

This year 12 follow-up inspections have been conducted, nine were within the six-month reporting period of this semi-annual report. This included follow up on 36 reports that included 418 findings and recommendations.

Compliance monitoring:

The semi-annual reporting process consists of written updates of progress completed by the facilities in the prior six months. This reporting process was implemented in July 2001, and will require progress reports submitted to the OIG from each facility on July 30 and January 30 of each year.

Chapter 5: SIGNIFICANT AREAS of CONCERN

There were 15 completed report packages during this semi-annual reporting period. Seven key themes surfaced as significant concerns from the findings identified:

1. Direct Care Staff Shortages – Of the ten facilities reported on during this period, four facilities were experiencing serious problems in maintaining adequate direct care staffing levels. Direct Care workers are the staff that are most involved in the hands on implementation of care and treatment at all these institutions. In order to achieve even minimal staffing levels, mandatory overtime was used. This situation was noted to result in increased job dissatisfaction and low morale among the staff interviewed as well as concerns regarding the well being of the residents.

Staff to resident ratios are a crucial element in the provision of on-going quality care. The majority of staff interviewed, from administration to direct care providers in each of these facilities, indicated that shortages in direct care staff poses the greatest challenges to the provision of quality care for the residents of the facility. These ranged from difficulties in securing adequate coverage, increased use of overtime, problems in effectively implementing established programs and active treatment goals for the residents and severely limiting the number of enhanced services that can be created and implemented.

As a result of the reviews, the OIG prepared a special briefing. The outcome was a proposal by the Inspector General to the Governor's office regarding the issues discovered and a solution. The IG worked closely with the Secretary of Health and Human Resources to create a positive outcome of this systemic issue. The Governor released funds to be used for immediate relief of staffing shortages. The ongoing monitoring of adequate staffing ratios will be part of the OIG inspection process as this directly relates to the quality of care provided to residents/patients within DMHMRSAS institutions.

Reference Findings from OIG reports:

- The majority of staff interviewed indicated that shortages in direct care staff poses the greatest challenges to the provision of providing quality care for the residents of the facility. (#44-01)
- Staff interviewed identified the required amount of regular mandatory overtime as the primary factor in increased job dissatisfaction and low morale. (# 43-01)
- Staff shortages are critical. (#34-00)
- Staff shortages are critical for nursing. Mandatory overtime is increasing used to provide minimal coverage. (#46-01)
- Given the degree of impairment of the individuals residing within the facility, there are inadequate ratio of direct care and professional staff to residents. (#39-01)
- There is considerable use of overtime at this facility. (#39-01)

Recommendation: Adequate staffing must be available to maintain quality care.

2. Professional staff shortages – Professional staff shortages were noted in several key positions at four of the ten facilities reviewed. Professional staff includes: occupational therapists, physical therapists, speech therapists, dieticians and nurses. Shortages in these professional staff were particularly pronounced at the four training centers reviewed. This often results in the professional staff only being able to serve the highest risk residents. Limited access by consumers to these valuable professionals results in lack of equitable access by all who could benefit from their expertise. The limitation in roles for these professionals results in a lack of input into administrative processes such as: injury prevention, risk management, performance improvement and environmental safety.

At one of the training centers, the addition of a single part-time physical therapist resulted in time-allotted for the rehabilitation of individuals previously considered to be wheelchair bound. These interventions enabled them to walk, which is associated with a decreased dependence on staff for mobility.

Two of the smaller training centers tried to free up resources by combining several key administrative functions. Concern was identified that continuing this practice would create a risk for severely compromising the supervision and oversight necessary to provide quality active treatment, residential and medical services. The ongoing monitoring of adequate professional staffing will be part of the OIG inspection process as this directly relates to the quality of care provided to residents/patients within DMHMRSAS institutions.

Reference Findings from OIG reports:

- There is a shortage in several key professional positions. (#43-01)
- The facility has used the combining of several key administrative positions in order to stretch resources. (#43-01)
- The staff maximizes its efforts to provide active treatment despite staffing limitations. (#44-01, #43-01)
- PT staff have a limited role, which restricts their capability to assist with facility-wide injury prevention (#34-00)
- There are an insufficient number of rehabilitation staff employees. (#34-00)
- The facility has designated the risk manager as the position that also serves as the abuse and neglect investigator. (#39-01)

Recommendation: Adequate professional staff must be available to provide effective quality care.

3. Access to adequate medical and psychiatric coverage-There is considerable variation among the facilities reviewed regarding access to primary medical care. This is particularly applicable at the training centers. Over the last thirty years there has been a significant shift in the populations being served by the training centers. Currently residents are living longer and are more medically and behaviorally complex. Most significant is the status of one of the training centers that has one primary care physician for a census of approximately 220 residents. This is in contrast to another training center with a comparable census and level of impairment that has

three primary care physicians. This inequitable distribution of resources within the state presents a significant challenge in providing adequate care for all the residents across the Commonwealth.

Limited psychiatric care within the four training centers is an important issue to be addressed within the facility system. Within the three training centers of comparable size the availability of a psychiatrist for a population of similarly impaired individuals ranges from two hours per week at one facility to 30 hours per week at another. At the MR facilities reviewed, approximately 40% of the residents were prescribed psychotropic medications. Psychiatric services benefit many of the residents in the training centers. Some of these benefits include but are not limited to accurate diagnosis, a review of outdated medications, the initiation of newer and safer antipsychotics and increased coordinated care. The ongoing monitoring of adequate professional staffing will be part of the OIG inspection process as this directly relates to the quality of care provided to residents/patients within DMHMRSAS institutions.

Reference Findings from OIG reports:

- The facility has limited access to a psychiatrist. (#44-01)
- There is a preponderance of old-fashioned antipsychotic medications in use at the facility. (#44-01)
- There are 14 individuals that remain on Thioridazine.
- There is one FTE primary care staff at this facility. (#43-01)
- A psychiatrist comes to the facility twice a month and is the equivalent to .05 FTE of psychiatric coverage. (#43-01)
- This facility currently has a part-time psychiatrist (20 hours) week. (#18-00)
- The residents in this facility in need of antipsychotic medications are receiving newer and safer generation medications [despite extremely limited psychiatric coverage] (#43-01)
- The population being served has shifted dramatically for this facility in recent years. (#23-00)

Recommendation: Access to adequate psychiatric staffing is not provided within all facilities and should be increased or modified.

4. Patient/resident safety – The ability to receive appropriate services in a safe environment is a basic quality care issue and essential factor in any review of a facility. The safety and security of those who have entrusted the Commonwealth with the provision of their care and treatment can never be taken lightly. One of the goals of the unannounced visits is to be able to view the facility at any given point in time to assure that the services are provided in an environment that is first and foremost safe.

The review of a safe environment encompasses a wide range of issues and concerns from the need for routine and consistent safety inspections of equipment and furniture; the Reference function of campus security; the adequate training of staff in safety practices; verification of background and reference checks of proposed employees. The OIG will continue to challenge the system to promote consumer safety through the inspection process.

Findings from OIG reports:

- Wire meshing over the windows in seclusion rooms presents a potential risk to patients (#23-00)
- The facility's system for conducting regular and routine safety inspections of equipment, furniture and the training of staff regarding safety practices needs to be enhanced. (#43-01)
- Facility staff would benefit from enhanced training regarding resident transport safety. (#43-01)
- The locked time-out room does not allow for continuous observation. (#44-01)
- The playground area presents a hazard to residents. (#44-01)
- Blinds, cords and electrical cording in resident rooms are potential hazards. (#44-01)
- New staff are allowed to have consumer contact prior to their background check information being secured. (#39-01)

Recommendation: Promote an increased emphasis on consumer safety.

5. Inadequate space or outdated facilities- The majority of the facility buildings are very old. This contributes to expensive maintenance of the outdated institutional environments. Shifts in the populations being served have evolved, resulting in buildings being used in a manner for which they were not designed. This requires an adaptation of the space, which is at times inadequate for effective programming. Additionally, there are a number of contemporary elements of technological infrastructure such as computerized ordering, labs and medication systems that are not feasible to implement in these aging buildings.

All of the facilities reviewed demonstrated efforts at creating a less institutional environment. The efforts varied but most were able to introduce inexpensive items that helped create a more personalized setting. Two facilities completed asbestos abatement projects, which were accomplished with little disruption to services. Each facility has been challenged with creating successful ways in which to utilize the space available in a safe and cost-effective manner. The consumer consultants have been particularly helpful in highlighting the important role that these environmental considerations play in providing a sense of well-being and value for individuals in the facilities. The OIG will continue to review the effect of facility infrastructure as an impediment to the quality of care provided.

Reference Findings from OIG reports:

- The facility is currently under renovation; enclosing "pony walls" per Medicare regulations. (#38-01)
- There is inadequate space for effective psychosocial programming to occur (#23-00)
- The facility has a very institutional presence and appearance. (#23-00)
- There are several second-hand temporary buildings parked outside the facility that are not being used. (#23-00)
- "Pony walls" in the C building are potentially dangerous and increase the unit's ward-like appearance. (#40-01)
- The majority of rooms designated for active treatment are limited in treatment space due to the number of residents in wheelchairs. (#43-01)

- The locked cottage creates both programmatic and human rights challenges for this facility. (#43-01)
- Cottage design for the most challenged individuals does not properly accommodate equipment or storage. (#39-01)
- All the space does not seem to be used in an optimal manner. (#44-01)
- Storage space is needed for unused equipment and excess supplies. (#44-01)

Recommendation: Ongoing consideration should be given to the cost vs. benefit of maintaining the current facility infrastructure.

6. Clinical Program and treatment concerns – The facilities have made considerable strides in the development of active treatment and in the creation of working treatment plans crafted in cooperation and with input from the patients/residents. Reviews revealed that continued efforts are needed in several facilities to fine-tune this process. Inadequate space and staffing shortages negatively impact effective planning and implementation of treatment.

All of the facilities reviewed have established programs providing active treatment programs for the patients/residents. Variations is quality were noted but these were often associated with other concerns such as adequate space or staffing patterns. There was evidence in each of the facilities that programming was for the most part based on patient preferences, with input from the patient/resident or authorized representatives and on identified barriers to effective community living. Most of the facilities have developed methods for assessing consumer satisfaction with the services offered and for measuring the number of hours of participation in active treatment.

Clinical Program and Treatment concerns have been identified in OIG reports prior to the semi annual reporting period. The OIG is monitoring these recommendations and has verified that ongoing improvements and upgrades are being instituted. The OIG will continue to challenge the facilities to provide high quality clinical care.

Reference Findings from OIG reports:

- Behavioral programming needs further development within this facility. (#23-00)
- A standing local human rights committee has not been in place for this facility since 1997. (#23-00)

Recommendation: Continue to strive to provide active treatment that is consistent with contemporary clinical guidelines.

6. **Documentation concerns-** Record reviews occurred during the majority of inspections completed by the OIG. These reviews provide information regarding the clinical course of treatment, the goals and objectives designed to assist the individual in returning to the community as well as the barriers that continue to present clinical challenges. All of the facilities have engaged in a process of enhancing the formation of treatment plans that reflect the individual's participation in developing realistic goals based on preferences. Of the concerns noted, debriefings with patients following the use of special procedures were not being consistently noted at two of the facilities. Inconsistencies were noted in the processes

for daily documentation of patient progress. Several facilities had not implemented new expectations regarding seclusion due to a delay in policy changes. The OIG will continue to monitor this critical function.

Reference Findings:

- Processes for daily documentation of patient progress by nursing staff were inconsistent. (#35-01)
- The current Medical Staff Policy and Procedure regarding seclusion is outdated. (#23-00)
- Treatment Plans did not consistently link the patient's barriers to discharge to psychosocial programming (#23-00)
- Record reviews revealed that debriefing of patients following incidents of seclusion and/or restraint are not consistently completed. (#40-01)
- The 48-hour report of this incident did not include complete information regarding the event. (#39-01)

Recommendation: Continue to promote adequate staff training regarding appropriate documentation of clinical interventions.

Chapter 6: Future Directions

The mental health, mental retardation and substance abuse services delivery system will continue to face many challenges. The crafting of services that are person centered, recovery oriented and designed to successfully make the most of public resources will require both a commitment and united vision among the various providers of publicly funded services.

The appointment of the Inspector General was created in such a manner as to straddle administrations, helping to provide consistency and the continuity of ideas and processes during a time of transition. This Office is committed to working within the new administration.

Over the next year, we anticipate incorporating two contemporary ideologies into our work. The first will focus on the promotion of evidence-based services, which is critical in planning for the delivery of publicly funded health care services. The second will incorporate ideas from the Institute of Medicine report entitled *Crossing the Quality Chasm.* This report proposes six aims for improvement in today's health care systems. According to this report "health care should be safe, effective, based on scientific evidence, person-centered, timely and equitable."

During the next six month reporting period, the OIG will enhance the monitoring of DMHMRSAS facilities through an examination of data and statistics collected, review of reports and projects associated with performance, and follow the Department of Justice's involvement in the facility currently under review.

The OIG will be continuing with onsite, unannounced inspections and follow-up inspections of the institutions. Consideration will be given to conducting clinical audits of components of community-based services as issues relevant to the Supreme Court Olmstead decision regarding the Americans with Disabilities Act become clarified.

Virginia's system has made numerous changes during the current administration and holds the promise for making additional strides in the provision of care for individuals with serious mental illness and or mental retardation.