COMMONWEALTH of VIRGINIA

Office of the Governor

Timothy M. Kaine
Governor

November 10, 2006

To Members of the Virginia General Assembly:

I am pleased to forward the Inspector General's semi-annual report of his inspections of mental health and mental retardation state facilities and licensed community programs in Virginia. The independent oversight of service quality offered by the Office of the Inspector General is a critical part of our efforts to improve behavioral health care in the Commonwealth.

During Jim Stewart's tenure as Inspector General, an effort has been made to conduct inspections and reviews in a more systemic fashion. As a result, we are able to provide a comparative picture of the quality of services statewide with the goal of encouraging more consistent quality and availability of facility and community services across the state. Every effort continues to be made to involve not only providers but also those who receive services and their families in the work of the Office.

I trust that you will find this report informative and helpful.

Sincerely,

Timothy M. Kaine

TMK/mkh

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COMMONWEALTH of VIRGINIA

Office of the Inspector General

James W. Stewart, III
Inspector General
for
Mental Health, Mental Retardation &
Substance Abuse Services

November 10, 2006

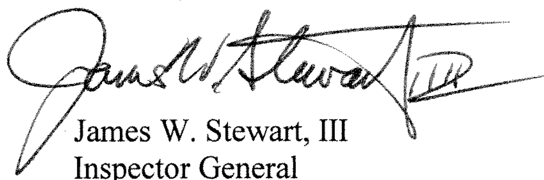
To the General Assembly of Virginia:

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) is pleased to submit this semi-annual report of activities for the period ending on March 31, 2005. This report is issued in accordance with the provisions of VA Code §37.2-425, which specifies that the Office report on significant activities and recommendations of the OIG during each six-month reporting period.

During the past six months the OIG focused on two major projects. The first was a series of follow-up inspections at the nine mental health hospitals that are operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The purpose of these reviews was to assess progress by the hospitals toward earlier recommendations by the OIG. The second project expanded our work with licensed community-based programs. This review examined the quality of community services board (CSB) substance abuse outpatient services for adults and provided a current assessment of the availability of CSB substance abuse services across the Commonwealth. In addition, our office evaluated progress by the Virginia Center for Behavioral Rehabilitation (VCBR) toward the development of more comprehensive treatment services for residents.

I am pleased to provide this summary of the activities of the Office of the Inspector General for your review.

Sincerely,



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Inspector General

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Office of the Inspector General For Mental Health, Mental Retardation And Substance Abuse Services

Semiannual Report April 1 – September 30, 2006

TABLE OF CONTENTS

	Page
Foreword	3
Highlight of Activities	5
Vision, Mission and Operational Values of the OIG	7
Activities of the Office	
A. Inspections and Reviews	9
B. Reports	10
C. Data Monitoring	11
D. Follow-up on Active Recommendations	11
E. Complaints, Concerns and Inquiries	12
F. Review of Regulations, Policies and Plans	12
G. Presentations and Conferences	12
H. Organizational Participation/Collaboration	13
Addendum A: Completed Inspection Reports	15

FOREWORD

The Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services (OIG) is pleased to submit this semiannual report of activities for the period ending on September 30, 2006. This report is issued in accordance with the provisions of Va. Code §37.2-425, which specifies that the OIG report on the significant issues related to the administration of the publicly funded services system.

This semiannual report outlines the accomplishments of the OIG from April 1 through September 30, 2006. Information regarding the inspections that have been conducted at state facilities and licensed community programs is included as well as summaries of OIG monitoring and review activities.

During the past six months, the OIG conducted follow-up inspections at 11 facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS) and a statewide *Review of Community Services Board Substance Abuse Outpatient Services for Adults*. The OIG released three reports regarding inspections/reviews that were conducted during the previous semiannual period. A summary of these efforts is provided in this report.

HIGHLIGHT OF ACTIVITIES

- The OIG carried out the following inspections and reviews of DMHMRSAS operated facilities and licensed community programs during this semiannual period:
  - A statewide review of substance abuse outpatient services for adults operated by the Community Services Boards. This review included visits to 25 CSBs, the completion of two statewide surveys, clinical record reviews, and interviews with staff and service users.
  - Follow-up inspections at the following 11 state facilities:
    - Catawba Hospital
    - Central State Hospital
    - Commonwealth Center for Children and Adolescents
    - Eastern State Hospital
    - Hiram W. Davis Medical Center
    - Northern Virginia Mental Health Institute
    - Piedmont Geriatric Hospital
    - Southern Virginia Mental Health Institute
    - Southwestern Virginia Mental Health Institute
    - Virginia Center for Behavioral Rehabilitation
    - Western State Hospital

- The following reports of reviews that were conducted during the previous semiannual period were completed and placed on the OIG website during this six-month period:
  - #126-05 Review of Community Residential Services for Adults with Mental Retardation
  - #127-05 Systemic Review of State-Operated Training Centers
  - #128-06 Review of Community Services Board Mental Health Case Management for Adults

- The Office reviewed 395 critical incidents during this six-month period. Additional inquiry and follow up was conducted for 88 of these incidents.

- The Office reviewed monthly quantitative data that was received from the sixteen DMHMRSAS operated facilities.

- The Office of the Inspector General reviewed the autopsy reports of 20 deaths that occurred at DMHMRSAS facilities.

- The OIG responded to 10 complaints/concerns and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period.

- A formal review of five DMHMRSAS regulations and policies was completed.

- The Inspector General and OIG staff made 16 presentations regarding the work of the Office and other topics at various conferences, statewide and local organization.

VISION, MISSION & VALUES

The Office of Inspector General was established to provide an independent system of accountability to the Governor, General Assembly, consumers and other stakeholders regarding the quality of the services provided by the sixteen facilities operated by DMHMRSAS and the network of public and private providers licensed by DMHMRSAS as defined in the VA Code, § 37.2-403.

Vision

Virginians who are affected by mental illness, mental retardation, and substance use disorders, and their families, will receive high quality, consumer focused services.

Mission

It is the mission of the Office of the Inspector General to serve as a catalyst for improving the quality, effectiveness, and efficiency of services for people whose lives are affected by mental illness, mental retardation, and substance use disorders.

Values to Guide the Work of the OIG

Consumer Focused and Inclusive
Quality Processes and Services
Integrity
Mutual Support and Teamwork
Respect
Creativity

ACTIVITIES OF THE OFFICE

A. INSPECTIONS AND REVIEWS

During this semiannual reporting period, the OIG carried out the following inspections and reviews of DMHMRSAS operated facilities and licensed community programs.

REVIEW OF COMMUNITY SERVICES BOARD SUBSTANCE ABUSE OUTPATIENT SERVICES FOR ADULTS

The OIG conducted a review of the statewide system of community services board (CSB) substance abuse outpatient services for adults during August 2006. This service was selected for review because drug and alcohol abuse and addiction are among the Commonwealth's most serious and complex public health problems, with far reaching consequences for families, employers, social services systems, and the criminal justice system.

The review included a survey to assess the range and capacity of all substance abuse services available in communities served by the 40 CSBs. OIG inspectors also conducted inspections at a sample of 25 CSBs, focusing on the one service that is provided in every community: adult outpatient services. During the site visits, interviews were conducted with 195 service recipients, 166 outpatient clinicians, and 73 division directors and supervisors. Approximately 240 service recipient case records were reviewed. The 43 local Probation and Parole Offices operated by the Department of Corrections were also surveyed as these agencies are the largest referral source for CSB substance abuse services.

The OIG developed a set of nine quality statements for substance abuse outpatient services based on stakeholder input and an extensive literature review. The Quality Statements included:

- A wide range of substance abuse services is available to meet the varied and changing needs of people in different stages of addiction and recovery, and services are matched to the specific needs and level of recovery of the persons served.
- Substance abuse services are readily available and affordable.
- Substance abuse services support the consumer's role in managing his or her own recovery.
- Consumers seeking services encounter a welcoming, supportive environment and feel supported and valued by the people providing services.
- Consumers and substance abuse staff share an interpersonal helping connection that has continuity and fosters trust and support for each consumer's recovery.

- The substance abuse and mental health needs of consumers are assessed and addressed in an integrated, inclusive, comprehensive manner.
- Persons in recovery receive case management services when needed for housing, transportation, employment, childcare, and other supports.
- Substance abuse staff has appropriate education, training, and supervision for their roles.
- Consumers show progress in recovery due to services that are objectively measured to be effective.

FOLLOW-UP REVIEWS OF STATE-OPERATED FACILITIES

During the months of May and June 2006, the OIG conducted unannounced inspections at eleven DMHMRSAS operated facilities, including:

- Catawba Hospital
- Central State Hospital
- Commonwealth Center for Children and Adolescents
- Eastern State Hospital
- Hiram W. Davis Medical Center
- Northern Virginia Mental Health Institute
- Piedmont Geriatric Hospital
- Southern Virginia Mental Health Institute
- Southwestern Virginia Mental Health Institute
- Virginia Center for Behavioral Rehabilitation
- Western State Hospital

This series of inspections were conducted to assess progress by DMHMRSAS and the facilities toward the successful completion of plans of correction regarding all outstanding active findings.

B. REPORTS

The OIG completed three reports during this six-month period. Reports are generated as a tool for performance improvement and provide information to the Governor, General Assembly, DMHMRSAS, consumers/families and providers regarding the findings, basis for findings and recommendations of the OIG. Following the receipt of each report, DMHMRSAS develops a plan of correction (POC) for each recommendation made by the OIG. Implementation of the plan of correction is monitored by the OIG until successful resolution has occurred. OIG reports can be found on the OIG website at www.oig.virginia.gov.

The following reports of reviews that were conducted during the previous semiannual period were completed and placed on the OIG website during this six-month period:

- #126-05 Review of Community Residential Services for Adults with Mental Retardation
- #127-05 Systemic Review of State-Operated Training Centers
- #128-06 Review of Community Services Boards Mental Health Case Management for Adults

C. DATA MONITORING

Critical Incident Reports

Documentation of critical incidents (CI) as defined by Virginia Code *§ 2.1-817*503 is forwarded routinely to the OIG by the DMHMRSAS operated state hospitals and training centers. The OIG reviewed 395 CI's during this semiannual period. An additional level of inquiry and follow up was conducted for 88 of the CI's that were reviewed.

Quantitative Data

In order to track potential areas of risk within the facilities on a routine basis between periodic inspections, the OIG receives monthly statistical data from each of the 16 DMHMRSAS operated facilities. Areas that are monitored include, but are not limited to, facility census, seclusion and restraint use, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect.

The OIG also receives reports from the Medical Examiner's office for each of the deaths that occur in the state operated facilities. The OIG reviews each of the autopsy reports with the participation of a physician consultant. During this reporting period, the Office of the Inspector General reviewed the autopsy reports of 20 deaths that occurred at DMHMRSAS facilities.

D. FOLLOW-UP ON ACTIVE RECOMMENDATIONS

All active or non-resolved findings from previous inspections are reviewed through a follow-up process until they have been successfully resolved. In general, evidence is required from at least two sources in order to recommend that the finding become inactive. The sources may include observations by the inspection team; interviews with staff and consumers; or a review of policies, procedures, memoranda, medical records, meeting minutes, or other documents.

There are currently 50 active recommendations for the state facilities and 70 active recommendations for licensed programs.

E. COMPLAINTS, CONCERNS AND INQUIRIES

The Office of the Inspector General responded to 10 complaints/concerns and inquiries from citizens, consumers and employees regarding a variety of issues during this reporting period. Of these contacts, one was a complaint/concern regarding DMHMRSAS licensed community programs; four were complaints/concerns regarding DMHMRSAS operated facilities; and five were requests for information or assistance.

F. REVIEW OF REGULATIONS, POLICIES AND PLANS

During this semiannual reporting period, the OIG reviewed and/or made comments on the following DMHMRSAS regulations, polices and plans:

- 12 VAC 35-210: Regulations to Govern Temporary Leave from State Mental Health and State Mental Retardation Facilities
- 12 VAC 35-105-925: Regulations Governing Issuance of Licenses to Providers of Treatment for Persons with Opioid Addiction
- 12 VAC 35-105-10: Amendments to Regulations for Licensing Providers of Services to Persons with Brain Injury
- 12 VAC 35-45-10: Regulations for Providers of Mental Health, Mental Retardation and Substance Abuse Residential Services for Children
- Regulations for Providers of Mental Health, Mental Retardation and Substance Abuse, and Brain Injury Residential Services for Children
- Policy 1008 (SYS) 86-3: Services for Older Adults with Mental Illnesses, Mental Retardation or Substance Use Disorder

G. PRESENTATIONS AND CONFERENCES

Inspector General Stewart or other OIG staff made presentations regarding the work of the office or served as the guest speaker for the following:

- Behavioral Health Subcommittee of the Joint Commission on Healthcare
- Briefings for Legislators and Executive Branch staff
- Briefing for Department of Planning and Budget (DPB) analyst
- Civil Admissions Advisory Council
- DMHMRSAS Advisory Consortium on Intellectual Disabilities (TACID)
- DMHMRSAS Facility Directors
- DMHMRSAS Training Center Directors
- DMHMRSAS System Leadership Council
- DMHMRSAS Medical Directors
- State Mental Health Planning Council
- Southside Virginia Training Center KOVAR Institute

- Virginia Association of Community Services Boards (VACSB) Conference
- VACSB Executive Directors Forum
- VACSB Mental Retardation Council
- VACSB Mental Health Council
- Virginia MHMRSAS Board

Staff of the OIG participated in the following conferences and trainings events:

- Board of Directors of the County Behavioral Health Institute
- Results-Based Budgeting sponsored by Comprehensive Services Act Office
- Federal Transformation Grant Review at DMAS
- DMAS Conference on Integration of Acute and Long Term Care
- Psychosocial Rehabilitation and Recovery Conference
- DMHMRSAS Co-occurring Mental Health and Substance Use Disorders Training by Minkoff and Cline
- Annual Conference of the Virginia Association of Private Providers
- VACSB May Conference

H. ORGANIZATIONAL PARTICIPATION/COLLABORATION

The OIG participated in a variety of forums and on various committees that address issues relevant to mental health, mental retardation and substance abuse and to state government:

- DMAS Medicaid Revitalization Committee Meetings
- DMHMRSAS Advisory Consortium on Intellectual Disabilities (TACID)
- DMHMRSAS Clinical Quality Services Management Committee
- DMHMRSAS Facility Director's meeting
- DMHMRSAS Licensing Review Advisory Committee
- DMHMRSAS Medical Director's meeting
- DMHMRSAS Office of Licensure
- DMHMRSAS Psychosocial Rehabilitation (PSR) Committee discussions
- DMHMRSAS Quarterly Staff meetings
- DMHMRSAS Restructuring Policy Advisory Committee
- DMHMRSAS Systems Leadership Council
- Civil Admission Advisory Council
- Governor's Agency Head Meeting
- Joint Commission on Health Care
- Region V Southeastern Virginia Training Center (SEVTC) downsizing meeting
- Supreme Court Advisory Group on Mental Health Reform
- Virginia Commission on Youth's Study of Establishment of an Office of Children's Services
- Virginia Office for Protection & Advocacy (VOPA) PAIMI Meeting
- VOPA Developmental Disabilities Meeting

The OIG staff met with the following agencies, organizations and other groups to seek input to the design of specific OIG projects:

- Consumers and family members
- Community Services Boards executive directors and program directors
- Department of Medical Assistance (DMAS)
- DMHMRSAS central office staff
- DMHMRSAS facility staff
- Mental Health Planning Council
- National Alliance on Mental Illness (NAMI)
- State Human Rights Council
- Virginia Association of Community Services Boards
- Virginia Network of Private Providers
- VOCAL (consumer leadership)
- Virginia Office for Protection and Advocacy (VOPA)

ADDENDUM A

COMPLETED INSPECTION REPORTS

April 1, to September 30, 2006

Review of Community Services Board Mental Health Case Management for Adults Report # 128-06

Quality of Care Finding A.1: Case management service users and case managers agree that consumers have a significant role in developing their own service plans, however, case management records fail to reflect this.

> **Quality of Care Recommendation A.1:** It is recommended that DMHMRSAS with the involvement of DMAS, CSBs and consumers, develop a model case management service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements.

Quality of Care Finding A.2: Case management service recipients have limited opportunity to exercise choice in the selection of case managers.

> **Quality of Care Recommendation A.2:** It is recommended that CSBs review case management service delivery methods and procedures to identify ways in which consumers can exercise greater choice as recipients of this service.

Quality of Care Finding B.1: Persons who receive adult case management services confirm that they receive the full range of case management services and that they consider each service to be important to them.

> No recommendation

Quality of Care Finding B.2: OIG inspectors found little evidence that case managers routinely evaluate the effectiveness of the services received by the consumer as a part of the individual service plan.

> **Quality of Care Recommendation B.2**: It is recommended that CSB case managers regularly assess the quality or effectiveness of services provided to consumers as a part of the individual service plan and the impact of these services on the consumer's quality of life.

Quality of Care Finding B.3: Consumers report that they are able to reach their case managers when needed during regular business hours but are not able to gain access to their case managers after hours and on weekends when they must deal with on duty staff in the emergency services program.

> **Quality of Care Recommendation B.3:** It is recommended that CSBs investigate the use of systems by which consumers can reach their own case managers in times of crisis so that they might speak to someone they know and trust rather than routinely having to deal solely with the emergency services system after regular business hours.

Quality of Care Finding B.4: Consumers of mental health case management services face severe shortages of core services needed for successful recovery in the community – affordable housing, reliable transportation, support to get jobs, peer support providers, timely access to psychiatrists, and affordable medications. Case managers cannot link and coordinate services that are not available.

> **Quality of Life Recommendation B.4.a:** In order to make available a more complete array of community services, it is recommended that DMHMRSAS and DMAS work cooperatively to seek avenues to steadily increase the capacity of the community services system to provide non-emergency support and clinical services.

> **Quality of Life Recommendation B.4.b:** It is recommended that DMAS investigate the cost and feasibility of covering dental services for Medicaid recipients.

Quality of Life Finding B.5: Consumers of mental health case management services report that their rights and privacy are protected by the CSB.

> No recommendation

Quality of Care Finding C.1: Case manager interviews and case management records do not reflect familiarity with or adoption of the recovery model.

> **Quality of Care Recommendation C.1:** It is recommended that DMHMRSAS initiate a collaborative effort with CSBs and consumers to develop a model training curriculum for mental health case managers and that this program be made available to all CSBs.

> Quality of Care Recommendation A.1 is also in support of this finding.

Quality of Care Finding C.2: Consumers express very high satisfaction with their case managers.

> No recommendation

Quality of Care Finding C.3: Few CSBs have mission/value statements that closely parallel the concepts found in the vision, mission, values statements of DMHMRSAS.

> **Quality of Care Recommendation C.3:** It is recommended that each CSB review it's mission statement and value statements and make any changes needed to assure consistency with the system wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the program reflect the organizational mission and value statements.

Quality of Care Finding C.4: CSB case management programs do not make extensive use of trained peer support providers ("recovery coaches") to augment and supplement services.

> **Quality of Care Recommendation C.4:** It is recommended that DMHMRSAS and CSBs research "recovery coach" models for involving peer support staff in case management and develop training programs to assist consumers in becoming qualified to provide this service. It is further recommended that CSBs offer peer support providers to complement and augment traditional case management services.

Quality of Care Finding C.5: Neither consumers nor case managers and supervisors expressed strong dissatisfaction or disapproval of the name case management. When informed that some consumers object to the term, most were open to considering alternative names for this service.

> No recommendation

Quality of Care Finding D.1: Both service recipients and case managers report that they experience their relationship as a strong, positive connection.

> No recommendation

Quality of Care Finding D.2: Consumers report that turnover of case managers is far too frequent to assure good continuity of care. Turnover of case managers varies significantly among CSBs.

> No recommendation

Quality of Care Finding E.1: The frequency of face-to-face contact by CSB mental health case managers with consumers is significantly higher than the minimum requirements of Medicaid.

> No Recommendation

Quality of Care Finding E.2: The location where case managers visit with consumers is split fairly evenly between home/community settings and office based settings.

Quality of Care Recommendation E.2: It is recommended that each CSB review current practice regarding the location where case managers visit with consumers to:

- Understand clearly what the current practice is.
- Identify barriers that may prevent visits in the location(s) preferred by consumers and most advantageous to the provision of effective services.

It is further recommended that each CSB:

- Assess whether or not current practice is consistent with consumer preference.
- Develop strategies for eliminating any identified barriers.
- Establish any guidance that may facilitate greater flexibility in where case management visits take place.

Quality of Care Finding E.3: Average caseload sizes for case management are higher than national standards and higher than case managers, supervisors, and consumers think is appropriate to ensure highest quality services.

Quality of Care Recommendation E.3.a: It is recommended that DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with serious mental illness and establish such a standard if it is determined advisable.

Quality of Care Recommendation E.3.b: It is recommended that DMHMRSAS seek additional resources to increase the number of CSB case managers who work with individuals with serious mental illness in order to lower the average caseload. If it is determined that a state standard for such caseloads is advisable, it is recommended that this standard serve as the guideline for determining how many additional case mangers are needed.

Quality of Care Finding E.4: Case management service recipients have the same access to and receive the same level of case management service regardless of eligibility for Medicaid as a payment source. However, Medicaid recipients do have greater access to other services such as mental health support services, transportation, affordable medications and outpatient services.

Quality of Care recommendation B.4.a is also in support of this finding.

Quality of Care Finding F.1: Case managers and supervisors have appropriate education levels for their positions.

No recommendations

Quality of Care Finding F.2: Case managers receive little training in topics specifically related to case management.

> **Quality of Care Recommendation F.2.a:** It is recommended that DMHMRSAS and DMAS, with the involvement of CSBs, study the value of developing certification standards for case managers.
>
> **Quality of Care Recommendation F.2.b:** It is recommended that CSBs consider the development of regional and/or statewide forums that will facilitate learning for case managers and enhancement of their professional role.
>
> Quality of Care Recommendation C.1.a is also in support of this finding.

Quality of Care Finding F.3: Case managers, supervisors – even many consumers – are of the opinion that paperwork requirements interfere with service provision rather than support it.

> **Quality of Care Recommendation F.3:** It is recommended that as DMHMRSAS and DMAS review and amend their respective regulations and inspection procedures that they seek ways to streamline and minimize data and record keeping requirements in an effort to allow case managers to maximize the amount of time they are available to consumers.

Quality of Care Finding F.4: Salaries for CSB case managers at some CSBs are very low. Low salaries are considered a major problem at some CSBs and contribute to high turnover and interference with the continuity of care.

> **Quality of Care Recommendation F.4:** It is recommended that each CSB conduct a review to determine if current salary ranges for case managers are having any negative impact on continuity of care for consumers who receive case management services and develop strategies to address any problems that are identified.