OIG SAR In-Brief

*The Office of the Inspector General created this Semi-Annual Report In Brief (SAR) to provide a synopsis of the key issues covered in greater detail in the full-length SAR for the period ending March 31, 2011, that can be found on the OIG's website at : www.oig.virginia.gov.**

Office of the Inspector General
Behavioral Health and Developmental Services

G. Douglas Bevelacqua
Inspector General

THE U. S. DEPARTMENT OF JUSTICE'S (DOJ) INVESTIGATION OF CVTC AND VIRGINIA'S COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT

By letter dated February 10, 2011, DOJ notified the Commonwealth of its findings that Virginia "fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA." The report cited inadequate community-based services, the misalignment of resources that privileges state institutions, and a flawed discharge planning process as systemic failures causing unnecessary institutionalization of persons.

Negotiations between the Commonwealth and DOJ are on-going and are expected to conclude this summer; however, it is certain that services for Virginians with behavioral health and developmental disabilities will be changed going forward as more people are discharged from state facilities, the waiver program is expanded, and these individuals are served by community-based programs instead of long-established institutional-based settings. A copy of the twenty-one page report containing DOJ's findings and recommendations is appended to the full-length SAR for convenient reference.

THE USE OF RESTRAINT TO MEDICATE OVER A PATIENT'S OBJECTION

A Federal regulation (42 CFR § 482) whose stated purpose is to "ensure each patient's physical and emotional health and safety" has been interpreted to disenfranchise scores of psychotic, but nonviolent, patients in Virginia's behavioral health facilities of medically necessary interventions that would allow them to participate in their treatment. The controlling interpretation of this Federal regulation, advanced by Virginia's Office of the Attorney General (OAG), rules out the use of a brief restraint to administer medically necessary treatment that could restore a delusional person to a baseline of competency, except to ensure "the immediate physical safety of the patient, a staff member, or others."

The narrow focus on *immediate physical safety* does not consider a patient's mental health and, while the OAG's guidance may protect the rights of most residents of state facilities, it falls short of promoting all patient's rights by potentially consigning some number of passive psychotic individuals to a needlessly protracted severe illness with attendant psychogenic distress – unless they either agree to medication or present an immediate risk to the physical safety of themselves or others.

Unfortunately, a regulation crafted expressly to limit the prerogatives of health care providers by creating negative covenants to protect hospitalized people has become an instrument that restricts the right of patients to active treatment that could ease their psychogenic pain and allow individuals to more fully participate in their lives.

By denying palliative care until *immediate physical safety* is on the brink of being

*The complete SAR includes a summary of inspections, investigations, and reviews conducted, reports issued, outstanding recommendations, and initiatives undertaken with the Creating Opportunities workgroups and a review of forensic services.

compromised, in some cases, the OAG's interpretation will allow a person's psychosis to deepen and, even after subsequent restraint and treatment, the person may never return to the pre-episode level of functioning. The refusal to provide medication deemed medically necessary by an attending physician for the health, safety, or welfare of the patient, with the express consent of the individual's legal guardian, satisfies the definition of neglect and abuse as described by the *Code of Virginia* 1950, *et seq.* at § 37.2-100.

The OIG became aware of this issue through a complaint filed by a legal guardian that her adult child was being denied prescribed treatment because the state hospital had been instructed not to use a medical hold to administer an anti-psychotic injection; however, this issue is much larger than one person. An informal survey by the OIG suggests that approximately 10% of patients in the Commonwealth's adult behavioral health facilities have psychotic episodes that do not initially endanger their immediate physical safety. When the patients who are court ordered for restoration to stand trial (currently numbering approximately eighty) and the geriatric patients with dementia are included in this population, the number of individuals statewide directly impacted by this narrow interpretation of 42 CFR § 482 is in the hundreds.

In discussions with the Attorney General's Office, the OIG was advised that its current interpretation of CFR 42 § 482 would stand unless they were instructed otherwise by the Centers for Medicare and Medicaid Services (CMS). Therefore, the OIG has petitioned CMS to review this matter to determine if restraint can be used to administer medically necessary treatment over the objection of a patient lacking the capacity to make informed decisions about their medical care – before a patient's immediate physical safety is jeopardized. A copy of the OIG's letter petitioning to CMS to resolve this ambiguity is appended to the full SAR that is available on-line.

QUALITY MANAGEMENT OF COMMUNITY-BASED RESIDENTIAL PROGRAMS

During the period covered by this SAR, the OIG has responded to complaints at two large community-based residential programs with serious operational issues. Fortunately, the DBHDS's Office of Licensing was fully engaged and aware of the issues at these two residential facilities and, subsequently, the Department has taken decisive action to monitor compliance with pertinent regulations; however, it is unrealistic to expect the Office of Licensing to drive quality improvement at community based residential programs.

In the years ahead, the individuals served by the Commonwealth's training centers and behavioral health facilities will increasingly be residing in community based settings, and the OIG is concerned that the state currently lacks a robust system to assure quality management of community based programs. The U. S. Department of Justice (DOJ) shares our apprehension and noted its concern in the recently received letter containing its findings of the investigation of CVTC and recommendations for remedial action (pg. 18).

During the next decade, several thousand individuals will be either discharged from the state facilities or living in community programs under an expanded waiver program and many new programs will be created, or existing programs expanded, to accommodate the demand.

Accordingly, in collaboration with the DBHDS, the OIG will design and conduct a comprehensive statewide survey of existing community based residential programs later this year to examine the quality performance of current residential models. Following the evaluation, recommendations will be made to create an effective quality management system that will act both as an

early warning system to identify (and correct) poorly operated programs, and to drive quality improvement among thriving community providers.

EASTERN STATE HOSPITAL

As of March 31, 2011, the census in ESH's 150 bed adult behavioral health unit was 153 persons, with 8 individuals still occupying the obsolete Building 24. The facility has been unable to discharge patients into community-based programs because the needed community capacity has not been created. CSB staff report that, in order to have someone admitted to ESH, the hospital must first discharge a current CSB client from ESH – the so called "bed replacement system."

The bottom line is that, as of March 31, 2011, ESH remains largely unavailable as a safety net for Hampton Roads residents requiring a secure state behavioral health facility. The lack of a regional intermediate care facility will continue to stress the region's behavioral health continuum of care. According to HPR V's Emergency Services Managers, over 40 consumers received inadequate care last year because ESH was not available to provide intermediate care to adequately stabilize the region's most fragile individuals with serious mental illness.

The Hancock Geriatric Treatment Center has been approved by the VDH's Office of Licensure for the Medicaid program and has reestablished it certification to participate in the Medicaid program effective March 14, 2011. This is a direct result of the effective leadership and hard work by the staff of ESH.

THE PRACTICE OF "STREETING" IN VIRGINIA

The OIG was introduced to the term "streeting" during our follow-up on the impact on Hampton Roads by the downsizing of ESH last year.[1] We subsequently learned that, while *streeting* appears most prevalent in Hampton Roads – where eight of nine CSBs acknowledge *streeting*, this practice occurs throughout the Commonwealth and, that between April 1, 2010 and March 31, 2011, approximately 200 individuals, who met criteria for a Temporary Detention Order (TDO), were released from custody because no psychiatric facility was willing to admit these people.

§37.2-808 of the *Code* lists the criteria for temporary detention: a person has a mental illness and is likely to cause "serious harm to himself or others," a "lack of capacity" to protect himself from harm or to provide for basic human needs and "is in need of hospitalization or treatment."

While there are variations in causes and frequency of this denial of access across the regions, there were sufficient numbers in each region for the OIG to determine that *streeting* is a state-wide problem. Cases that satisfy the HPR V definition of "streeted" vary in complexity and level of risk and the OIG received anecdotal reports from around the state. The record also reflects that emergency services staff around the state routinely go far beyond reasonable expectations to keep clients as safe as possible despite sometimes daunting obstacles.

As one of only two mental health services mandated by the *Code*, the Virginia General Assembly (GA) has given considerable attention in the past to the process of

[1] The instructions for completing the "HPR V Emergency Services Weekly TDO Report" contain the following operational definition of streeting: "# **Streeted**: The person was released. For example, a person who is brought in under ECO, who meets [TDO] criteria, but has to be released from custody at the expiration of the ECO as there is no bed available." [Bold in original] Of the approximately 200 people "streeted," not all were detained pursuant to an ECO prior to evaluation for TDO.

securing and carrying out emergency services for citizens of Virginia who may be at-risk to self, or others, for harm due to their mental illness. The GA renewed its focus on emergency services following the tragic deaths at Virginia Tech in 2007, which resulted in several key changes in the delivery of emergency services in Virginia.

To deny individuals an opportunity to receive the services, at the level of care deemed clinically and legally necessary, places each person at risk not only at the time of the immediate crisis but may create avoidable risk for the person and the community later.

Streeting represents a failure of the Commonwealth's public sector safety net system to serve Virginia's most vulnerable citizens and places these individuals, their families, and the public at-risk. The fact that approximately 200 individuals, who were evaluated by skilled clinicians and determined to be a danger to themselves or others and lacking the capacity to protect themselves, were denied access to a secure environment for temporary detention and further evaluation, greatly concerns the OIG.

We will monitor this issue going forward and make recommendations to end this questionable and dangerous practice, and hope that one day the term *streeting* will pass from the lexicon of Virginia's behavioral health system.

VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION (VCBR)

In 2004, Virginia created a program for the treatment of sexually violent predators (SVP) and subsequently established VCBR to accommodate the program serving this population. This treatment program has presented long-standing concerns for the OIG. Past inspections have consistently documented concerns at the facility including: limited treatment opportunities provided the residents; inadequate treatment planning; failed programming initiatives; and inadequate staffing to assure safety and effective programming.

In the last year, the DBHDS has replaced VCBR's facility Director and recruited a new clinical Director who has authored several important books on SVPs and is widely regarded as an expert in the treatment of this population. These leadership changes appear to have stabilized the serious security concerns at VCBR and generated a credible treatment program for the residents, but these promising developments must be given time to mature before the significant problems noted in OIG Reports since 2007 are considered resolved.

The cost of operating this program has skyrocketed as the population has grown from 14 in 2004 to over 260 today, and it is projected to increase by 7 individuals each month through 2016 at a cost per person of $91,000/year – plus facility cost. The General Assembly has directed a comprehensive study of this program to be completed later this year. The unforeseen cost of this program and the on-going operational transition may present an opportunity to evaluate the Commonwealth's civil commitment statutes and the treatment of sexually violent predators.

If you would like more information about these issues, or other activities of the Office of the Inspector General for Behavioral Health and Developmental Services during this reporting period, please refer to the full-length SAR at www.oig.virginia.gov, call (804) 692-0276, fax your questions to (804) 786-3400, or write to:

Office of the Inspector General
P. O. Box 1797
Richmond, Virginia 23218-1797

COMMONWEALTH of VIRGINIA

Office of the Inspector General

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May 30, 2011

To: Governor Robert F. McDonnell
The General Assembly of Virginia
The Joint Commission on Health Care

The Office of Inspector General (OIG) was established by the *Code of Virginia* § 37.2-423 to provide an independent system of accountability to the Governor, the General Assembly, service recipients and other interested parties for the services provided by the state operated facilities and the network of public and private providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS).

We are pleased to submit this Semi-Annual Report (SAR) for the period ending March 31, 2011 pursuant to § 37.2-425 of *The Code* that requires the OIG report periodically on its activities and outstanding recommendations, and to provide a description of significant systemic problems, abuses, and deficiencies.

In addition to the attached Report, we have included the *OIG SAR In-Brief* that presents a synopsis of the key issues covered in the full-length Semi-Annual Report. We created this abbreviated version to provide an accessible rendering of the Report that can be more easily consumed by interested persons.

During the six months covered by this Report, the OIG has conducted unannounced inspections at nine (9) facilities operated by the DBHDS and two (2) private facilities licensed by the DBHDS. We are pleased to provide for your consideration a summary of these and other activities in this Semi-Annual Report.

Sincerely,

G. Douglas Bevelacqua
Inspector General

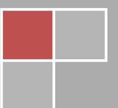
2011

OIG Semiannual Report

October 1, 2010 to March 31, 2011

Office of the Inspector General
Behavioral Health and Developmental Services

G. Douglas Bevelacqua
Inspector General
May 11, 2011



COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

May 27, 2011

General Assembly of Virginia
Capitol Square
Richmond, Virginia

Dear Members of the General Assembly,

In November, I wrote to you about many of the issues facing Virginia's delivery of behavioral health and developmental services and our efforts to move towards a more community-based model. Since my communication, I am pleased to report that we are making progress in a number of critical areas. As I have stated, we will not solve all of the problems during my time in office, but together we can make a significant impact.

As you know, the Commonwealth is currently engaged in discussions with the Department of Justice related to the care provided in our state training facilities. I am confident the historic investment we made together this year through the down payment and the trust fund, will modernize care for individuals with intellectual and developmental disabilities. Most significantly, this investment will help strengthen the appropriate infrastructure to provide high quality care in community settings. This will provide an opportunity for individuals residing in the training centers to move into the community and ensure that those who need care in the community can remain among their friends and family while receiving care.

I am pleased that we have regained certification from the Centers for Medicare and Medicaid Services at the Hancock Geriatric Center at Eastern State Hospital, and I extend my gratitude to all of the employees at the Center. The facility would have not regained its certification without their hard work and dedication.

In addition, I want to thank Commissioner Stewart and the entire staff at the Department of Behavioral Health and Developmental Services. They are on the front lines of our transformation. The issues outlined in the attached Inspector General's Report are important, and I am pleased that the Commissioner, working with Inspector General Bevelacqua, has started to address a number of these issues. Attached to this letter, you will find a list of issues that have been addressed since I took office in January 2010.

In closing, I want to thank each of you for the partnership and bipartisan fashion that has been taken to solve these problems. There may be differing opinions regarding how to solve the issues, but we all agree they must be solved. With this as our goal, we will achieve great results.

Sincerely,

Robert F. McDonnell

RFM/kfs

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Department of Behavioral Health and Developmental Services
Summary of Efforts to Address Major Issues
January 2010 to April 2011

Leadership

- Restructured DBHDS
  - To enable greater integration of facility and community developmental services
  - To enable greater integration of facility and community behavioral health services
  - To bring all quality management and development functions into one division
- Put new executive team in place
- Replaced 6 out of 15 facility directors, the most significant of which were ESH, CVTC and VCBR
- Set stage to reestablish DBHDS medical director
- Set stage to provide stronger leadership for IT

Strategic Planning – Creating Opportunities: A Plan for Advancing Community-Focused Services

- The plan addresses the following areas and has involved approximately 200 individuals
  - Behavioral Health Services Initiatives
    - Strengthen responsiveness of emergency response system
    - Develop infrastructure to increase peers in direct service roles
    - Enhance access to consistent array of substance abuse treatment
    - Enhance effectiveness and efficiency of state hospitals
    - Develop/& implement plan for child mental health services
  - Developmental Services Initiatives
    - Build community services and supports capacity
    - Provide leadership and participate in interagency planning for services to individuals with developmental disabilities including autism
  - System-Wide Initiatives
    - Address housing needs
    - Create employment opportunities
    - Strengthen capability of case management system
  - Other major initiatives
    - Participate in healthcare reform
    - Address sexually violent predator service capacity issue
    - Implement electronic health record (EHR)

Select List of Other Major Accomplishments

- Successfully consolidated all public child and adolescent inpatient services at CCCA and closed adolescent unit at SWVMHI.
- DBHDS Forensic Services developed a pilot program for conducting forensic assessments via video teleconference.
- Completed update and revision of Training Center Admissions and Discharge Protocols.
- DBHDS expanded its audit program of local CSBs.
- Office of Licensing licensed 120 new provider organizations and completed 724 investigations including major investigations at The Pines and the Robert E. Rose Foundation.

Reviews of DBHDS by External Agents

- Training Centers
  - 4 of 5 training centers reported successful CMS surveys with only one visit
  - SVTC had multiple CMS visits and POC was accepted
- State Hospitals
  - 5 of 5 hospitals reported very positive Joint Commission surveys
  - 3 of 4 hospitals reported successful CMS surveys. Following the loss of recertification for CMS Medicaid in September 2010, Hancock Geriatric Treatment Center utilized consultants who worked with staff to correct the deficiencies. A Plan of Correction (POC) was submitted and accepted resulting in HGTC being awarded full certification effective March 14, 2011.

Major Capital Projects

- Eastern State Hospital – New 150 Bed Adult MH Treatment Facility
  - Construction completed in August 2010.
  - Occupancy began in August and was completed at the end of September.
- Downsizing of Southeastern Virginia Training Center
  - Construction of 15 new homes on campus is 20% complete
  - Community Housing: 6 homes will be completed by July; others underway with completion in 6 to 9 months
- Downsizing of Central Virginia Training Center
  - Construction continues on the renovation of buildings 8 and 12. Completion anticipated within 4 months; will advertise for construction bids on building 9 within next 60 days.
  - Have vacated a total of 10 buildings within last year. Anticipate this trend to continue
  - Community Housing: Negotiations underway with 5 CSBs for waiver homes and ICF homes
- Construction of a replacement facility for Western State Hospital
  - Foundations are complete and structural steel is in progress
  - Anticipated project completion in late spring/early summer 2013

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1. U. S. Department of Justice letter of February 10, 2011, styled: *Investigation of the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center.*

2. Letter from the Office of the Inspector General, Behavioral Health and Developmental Services to Donald M. Berwick, M.D., Administrator, Centers for Medicare and Medicaid Services captioned: Urgent Request for Clarification concerning *the use of restraint to medicate over patient's objections: 42 CFR Part 482.*

FOREWORD

The *Mission* of the Office of the Inspector General (OIG) is to provide an independent system of accountability to the Governor, the General Assembly, and the citizens of the Commonwealth for the quality of services provided by the Department of Behavioral Health and Developmental Services (DBHDS), and other licensed providers of behavioral health and developmental services, in order to protect the health and welfare of service beneficiaries.

The OIG's *Mission* is authorized by the *Code of Virginia* §§ 37.2-423, 37.2-424, & 37.2-425 that requires the Office to inspect, monitor, and review the quality of services in state facilities, and other licensed providers, and to make policy and operational recommendations in response to complaints of abuse, neglect or inadequate care.

To support its *Mission*, the OIG reports semi-annually to the Governor, the General Assembly, and the Joint Commission on Health Care concerning significant problems, abuses, and deficiencies relating to the programs and services of state facilities and other licensed providers.

The Code requires that the Semi-Annual Report (SAR) identify "each significant recommendation, described in previous reports under this section, on which corrective action has not been completed." The results of this review are contained in the section of this SAR captioned *Significant Outstanding Findings and Recommendations from Past OIG Reports*.

Semi-Annual Report

Office of the Inspector General

Behavioral Health and Developmental Services

October 1, 2010 to March 31, 2011[1]

ACTIVITIES OF THE OFFICE OF INSPECTOR GENERAL

INSPECTIONS, INVESTIGATIONS AND REVIEWS CONDUCTED BY THE OIG

The OIG is required by *Code* § 37.2-424.3 to conduct at least one unannounced visit annually at each of the fifteen state-operated behavioral health and developmental services facilities. Unannounced visits are conducted at a variety of times and across different shifts. During this semi-annual reporting period, the office conducted unannounced visits at the following state facilities and licensed programs:

- Western State Hospital in Staunton
- Commonwealth Center for Children and Adolescents in Staunton
- Southwestern Virginia Mental Health Institute in Marion
- Catawba Hospital in Catawba
- Southwestern Virginia Treatment Center in Hillsville
- Virginia Center for Behavioral Rehabilitation in Burkeville
- Eastern State Hospital in Williamsburg
- Central Virginia Training Center in Lynchburg
- The Rose Memorial Foundation (licensed group home) in Winchester
- The Pines (Crawford Campus), in Portsmouth

The OIG published reviews of the *Downsizing of ESH and the Impact on the Hampton Roads Area* and a snapshot inspection of The Pines (Crawford Campus) in Portsmouth, VA during this reporting period. Also, the OIG commenced monitoring the *Creating Opportunities* Workgroups that will guide system transformation and initiated a review of facility-based forensic services.

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1 In an effort to make this material more accessible and user friendly, key issues in this Semi-Annual Report, covering the period October 1, 2010 to March 31, 2011, are summarized in the SAR In-Brief that can be found on the OIG website at: www.oig.virginia.gov.

The OIG generates three types of reports: Inspections, Investigations, and Reviews. A brief description of each type of report created by the OIG follows:

INSPECTION REPORT: The purpose of an inspection by the OIG is to assess the quality of care provided by a facility or program. The focus may be on any aspect or service delivery, treatment, or operations. Inspections will normally include assessments related to some aspect of active treatment, staffing, and the service delivery environment. An inspection may be conducted to follow-up on progress made by a provider in response to earlier OIG findings and recommendations. Inspection reports are routinely placed in the public domain, via the OIG's website, after the OIG has accepted the provider's response to findings and recommendations.

INVESTIGATION REPORT: An investigation is conducted by the OIG in response to a specific incident, complaint, or event. The purpose of an investigation is generally to determine if abuse or neglect has occurred, inadequate quality of care has been provided, or a policy/procedure has been violated. The incident, complaint or event may come to the attention of the OIG through a variety of avenues: email, phone call or letter from an individual, a service provider, DBHDS, or any other source. An investigation most often, but not always, will involve a site visit to a facility or program. The investigation process may include: interviews with the complainant(s), service recipient, family members, provider staff and/or others, the review of policies/procedures and records, observations, and analysis or assessment of pertinent data. Each investigation will be documented in a report, and the report may include one or more findings and recommendations if the findings warrant specific actions by the provider, DBHDS or other parties. Investigation visits to providers can be announced or unannounced. Investigation reports will normally remain classified as "Confidential Governor's Working Papers" because they contain confidential information about service recipients, family members or provider staff.

REVIEW REPORT: A review by the OIG is a series of inspections that focus on the quality of care provided by a system of care. The system of care on which the review focuses may include all state facilities, all state facilities of a similar type (behavioral health hospitals or training centers), all community services boards (CSBs), a region of CSBs or providers, all providers (public and private) that serve a defined population, or any other combination that is identified by the OIG. Each review will be documented in a report, and the report may include one or more findings and recommendations if the findings warrant specific actions by the providers, DBHDS or other parties.

SUMMARY OF SIGNIFICANT PROBLEMS, ABUSES, & DEFICIENCIES

THE USE OF RESTRAINT TO MEDICATE OVER PATIENTS' OBJECTIONS:

BACKGROUND: It is ironic that a Federal regulation whose stated purpose is to "ensure each patient's physical and emotional health and safety" disenfranchises scores of psychotic, but nonviolent, patients in Virginia's behavioral health facilities who are denied medically necessary interventions that would allow them to participate in their own lives. The controlling interpretation of this Federal regulation, advanced by Virginia's Office of the Attorney General (OAG), rules out the use of a brief restraint to administer medically necessary palliative treatment that could restore a delusional person to a baseline of competency, except to ensure "the immediate physical safety of the patient, a staff member, or others."

In other words, regardless of an individual's capacity to make informed decisions about their medical care, a nonviolent psychotic patient can only be medicated if they agree to the injection, and a delusional person, lacking the capacity to make informed decisions, can only be restrained to be medicated once the *immediate physical safety* to self or others threshold has been crossed. A seriously mentally ill person, lacking capacity, who poses no danger to his/her immediate physical safety, cannot be medicated – unless they agree to the treatment.

While the case profiled below is only one patient in an adult behavioral health facility, the controlling interpretation of the OAG has been extended to the forensic and geriatric populations. Persons who have been court ordered for restoration of competency to stand trial may not be medicated without their agreement. Likewise, geriatric patients with dementia cannot be restrained for an injection so long as their behavior does not jeopardize the immediate physical safety of the person, a staff member, or others.

INVESTIGATING THE GUARDIAN'S COMPLAINT: On March 15, 2011, the OIG received a complaint from a court appointed guardian requesting that the OIG investigate the refusal of a state behavioral health facility to employ a medical hold (a restraint) to inject the patient, also her adult child, with an anti-psychotic drug that, in the past, had been effective in treating the patient's severe mental illness. The patient's guardian noted that, without this drug, the patient was sinking further into a psychotic state and the legal guardian was concerned that prolonged psychosis could cause permanent damage and that the patient may never return to their previous level of functioning.

The OIG's investigation revealed that the attending psychiatrist and the patient's treatment team had recommended he/she be administered an injection of a long acting anti-psychotic medication, but that the patient had objected to the injection believing that he/she was a government official and that the drug was intended to cause him/her to divulge national

security secrets. In interviews with this patient, the OIG confirmed clinical reports that he/she had persistent and detailed delusions.

The hospital had been advised by the OAG that using restraint to medicate over a patient's objection was a violation of Federal regulations as articulated at 42 CFR § 482.13(e) *Standard: Restraint or seclusion* and, therefore, the facility could not follow the recommendation of the attending psychiatrist and treatment team, who deemed this intervention to be medically necessary, or the instructions of the legal guardian to whom the court had conveyed the specific authority to make medical decisions on behalf of this legally incapacitated person.

DISCUSSION: The OAG's guidance to the Commonwealth's state facilities is supported by 42 CFR § 482.13(e) and responses to the public comments preceding the promulgation of this regulation published in the *Federal Register* that state in relevant part:

> 42 CFR § 482*(e) Standard: Restraint or seclusion:* All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
>
> Often with the best intentions, a patient or the patient's family may ask for a restraint to be applied…A request from a patient or family member for the application of a restraint which they would consider to be beneficial is not a sufficient basis for the use of a restraint intervention. Regardless of whether restraint use is voluntary or involuntary, if restraint (as defined by the regulation) is used, then the requirements of the regulation must be met….[2]

When read together, these two excerpts appear to support the conclusion that, absent an emergency involving "immediate physical safety," a restraint could not be used to administer medication. Based on the foregoing, the OAG has concluded that "restraint can never be consented-to." This interpretation of the regulations effectively eliminates the practice of treatment over objection because the only accepted means of administering non-emergency medication, consistent with this interpretation, is with a patient's consent.

The plain language of Part 482(e) provides an important safeguard of the rights of those individuals who have the capacity to participate in an informed medication decision-making

[2] *Federal Register*, Vol. 71, No. 236, *Rules and Regulations*, pg. 71387.

process. All patients have the right to refuse medication – providing that the individual has the capacity to understand the consequences of the decision; however, the OAG's guidance, based on the responses to public comments about the proposed regulation in the *Federal Register,* does not allow for restraint for interventions deemed medically necessary by attending physicians with the concurrence of the legal guardians or authorized representative unless the "immediate physical safety" of a patient, staff member, or others is at stake.[3]

An informal survey of the facilities by the OIG revealed that the case profiled above is representative of approximately 10% of the patients residing in state adult behavioral health facilities. Namely, people whose mental illness diminishes their capacity to make informed medical decisions, but who are not presently violent and, hence, do not constitute a threat to their *immediate physical safety*. Under this standard, a passive psychotic person is consigned to a world of persistent and perhaps deepening psychosis and denied proven interventions deemed medically necessary – even if requested by their AR or guardian, until their immediate physical safety is at risk.

The interpretation of the CFRs denying guardians, and even the patients themselves, to authorize restraint to medicate over objection is reasonable given the language cited above; however, such an interpretation must read silent critical values articulated in the SUMMARY section of 42 CFR Part 482 and repeated throughout in the above referenced *Federal Register* stating that the regulation " …contains standards that ensure minimum protections of **each patient's physical and emotional** health and safety[4], and codified at § 482.13 *Conditions of participation: Patient's rights*: A hospital must protect and promote **each patient's rights**." [Bold supplied by OIG]

The narrow focus on *immediate physical safety* does not adequately consider a patient's mental health or psychogenic pain and, while the OAG's guidance may protect the rights of most residents of state facilities, it falls short of promoting each patient's rights by potentially consigning some number of nonviolent psychotic individuals to a needlessly protracted severe illness – unless they either agree to medication or present an immediate risk to physical safety.

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[3] This patient's personal hygiene deteriorates as their mental illness deepens. According to the "immediate physical safety" standard for employing restraint to treat a person, the hospital would be required to wait until a person's urine, or feces, was causing sufficient skin damage to threaten their "immediate" health in order to restrain this person to wash them.

[4] *Federal Register*, Vol. 71, No. 236, *Rules and Regulations*, pg. 71378.

A number of troubling questions arise from the case profiled above and the controlling OAG interpretation of 42 CFR § 482:

1. How can an individual be determined to have the capacity to agree to – or to refuse the administration of a medication, when that same individual has been found by a Court to be incapable of making informed decisions and in need of a guardian to make decisions to protect his/her from abuse or neglect?

2. How can the Commonwealth ignore a court *Order* that requires the privileging of a guardian's judgment over that of a person found to be incapacitated?

3. Can the Commonwealth ignore a specific court *Order* for medication over objection when it is issued pursuant to an existing court *Order* for treatment to restore competency to stand trial?

4. How can the Commonwealth ignore the medical advice of the treating physician who states unequivocally that this treatment is medically necessary for his patient?

5. Does a patient, capable of making an informed decision about his/her medical care, have the right to formulate an advance directive requesting that hospital providers use restraint to administer anti-psychotic drugs?

6. If an individual creates a valid advance directive, is hospital staff required to honor the patient's directive?

7. If a hospital is not obligated to honor a patient's advance directive requesting to be restrained to administer anti-psychotic drugs, how can this be reconciled with 42 CFR 482.13(b)(3) that contains the following provision:

> The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates).

In the responses to public comments published in the *Federal Register* concerning 42 CFR 482, the Centers for Medicare and Medicaid Services (CMS) stated that:

> This regulation is not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need appropriate therapeutic doses of medications to improve their level of functioning so that they can actively participate in their treatment.[5]

However, the OAG's current interpretation of the regulations clearly "interfere[s] with the clinical treatment of patients" by denying a medical restraint to administer "therapeutic doses of medications" to allow passively psychotic patients to "actively participate in their treatment."

The same volume of the *Federal Register* also states that individuals have "the right to be free from restraints of any form that are not **medically necessary**…." [Bold supplied by OIG][6] Yet, the OAG's interpretation prohibits the use of restraint needed to administer treatment that has been deemed *medically necessary* by a patient's treatment team and the attending psychiatrist.

As noted above, the OAG has determined that "restraint can never be consented-to" based on its reading of the *Federal Register* that states in relevant part:

> Often with the best of intentions, a patient or the patient's family may ask for a restraint to be applied…If a need is confirmed, the practitioner must then determine the type of intervention that will meet the patient's needs with least risk and most benefit to the patient. A request from a patient or family member for the application of a restraint which they would consider to be beneficial is not a sufficient basis for the use of a restraint intervention.[7]

When this provision is read in its entirety, it does not affirm that restraint can never be consented-to. Rather, in the OIG's opinion, this provision states that a patient or family member's request for restraint is insufficient until reviewed and endorsed by the treating medical practitioner familiar with innovative and less restrictive alternatives that comply with the provisions of 42 CFR § 482.

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[5] *Supra*, pg. 71386.

[6] *Supra*, pg. 71385.

[7] *Supra*. Pg. 71387.

The title of 42 CFR § 482 is *Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights* and, as the title suggests, its stated purpose is to protect patients' rights by setting forth the conditions for hospital participation. Thus, this regulation was expressly created to protect and promote patient rights by restricting the actions of hospitals participating in the Medicaid and Medicare programs. In the OIG's view, the interpretation of the OAG is flawed because it would restrict the rights of a competent patient to enter into an advance medical directive authorizing restraint for treatment. This interpretation also restricts a passive patient's right to be administered medically necessary medications that would allow them to participate in their treatment – until their condition deteriorates to a point threatening their immediate physical safety.

Unfortunately, a regulation crafted expressly to limit the prerogatives of health care providers by creating negative covenants to protect hospitalized persons has become an instrument that restricts the right of patients to active treatment that could ease their psychogenic pain and allow individuals to more fully participate in their recovery.

THE CODE OF VIRGINIA: Notwithstanding the foregoing discussion, the refusal to provide treatment deemed medically necessary by an attending physician for the health, safety, or welfare of the patient, with the express consent of the individual's legal guardian, satisfies the definition of neglect and abuse as described by the *Code of Virginia* 1950, *et seq*. that defines neglect and abuse at § 37.2-100:

> "Neglect" means failure by an individual or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, **treatment**, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse.
>
> "Abuse" means any act **or failure to act** by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, **and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation, or substance abuse.** [Emphasis supplied by OIG]

In discussions with the Attorney General's Office, the OIG was advised that its current interpretation of CFR 42 § 482 would stand unless advised otherwise by CMS. Therefore, the OIG has petitioned CMS to review this matter to determine if restraint can be employed to administer medically necessary treatment over the objection of a patient lacking the

capacity to make informed decisions about their medical care – before a patient's immediate physical safety is jeopardized. A copy of the letter to the Administrator of CMS is appended to this Report.

VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION (VCBR):

In 2004, Virginia created a program for the treatment of sexually violent predators (SVP) and subsequently established VCBR to accommodate the program serving this population. The facility originally housed 14 individuals with a budget of $4.1 million. Today, VCBR operates a 300-bed facility in Burkeville with a FY 2012 budget of $24 million (and growing) and a census of 260 that is reliably projected to increase by 7 individuals each month though FY 2016. The annual cost per resident, not including facility cost, is estimated at $91,000.[8] The rapid growth in this population, combined with the skyrocketing cost of operating this facility, was noted during the last session of the General Assembly who directed a comprehensive study of this program be submitted to the legislators later this year.

This program has presented long-standing concerns for the OIG. Past inspections by the OIG have consistently documented concerns at the facility including, but not limited to: limited treatment opportunities provided the residents; inadequate treatment planning; failed programming initiatives; and inadequate staffing to assure safety and effective programming.

Ongoing concerns resulted in the 2008 OIG recommendation that a permanent advisory committee be established to provide consultative support to the facility's leadership team in making operational and programming decisions. The OIG was informed by DBHDS that the advisory committee has not met since the hiring of the new facility director in August 2010. While the change in leadership has resulted in positive changes at this facility, it may be premature to suspend the work of the advisory committee during this critical period.

When the OIG conducted an unannounced visit at the facility in February 2011, the OIG inspection team was informed of other changes in the leadership structure that had occurred just prior to the visit, including the hiring of the Director of Healthcare Compliance whose responsibilities include the formation of quality improvement initiatives within the setting. The OIG's Report, documenting the inspection of this facility, will be issued as a

[8] This program initially evaluated offenders for involuntary civil commitment if they had been convicted of four predicate offenses. Currently there are 28 predicate offenses that trigger evaluation for civil commitment to VCBR. By FY 2016 the projected 684 residents will require an annual operating budget exceeding $62 million – plus additional tens of millions to construct new facility(s). (The 300-bed Burkeville facility was constructed in 2008 at a cost of $65 million.)

separate document this spring, but the bottom line is that the OIG visit found the conditions at VCBR greatly improved since an alarming March, 2010 OIG investigation.

In the last year, the DBHDS has replaced VCBR's facility Director and recruited a new clinical Director who has authored several important books on SVPs and is widely regarded as an expert in the treatment of this population. These leadership changes appear to have stabilized the serious security concerns at VCBR and generated a credible treatment program for the residents, but these promising developments must be given time to mature before the significant problems noted in OIG Reports since 2007 are considered resolved.

The unsustainable cost of this program and the on-going operational transition may present an opportunity to evaluate the Commonwealth's civil commitment statute and its treatment of sexually violent predators.

THE PRACTICE OF "STREETING" IN THE COMMONWEALTH:

The OIG was introduced to the term "streeting" during our follow-up on the impact on Hampton Roads by the downsizing of ESH last year.[9] We subsequently learned that, while *streeting* appears most prevalent in Hampton Roads – where eight of nine CSBs acknowledge *streeting* last year, this practice occurs throughout the Commonwealth and, that between April 1, 2010 and March 31, 2011, approximately 200 individuals, who met criteria for a Temporary Detention Order (TDO), were released from custody because no psychiatric facility was willing to admit these people.[10]

In order to understand the extent of this problem, the OIG conducted an informal survey of emergency services directors across the state. Twenty three of the forty community services boards acknowledged having cases where *streeting* occurred last year. Data

[9] The instructions for completing the "HPR V Emergency Services Weekly TDO Report" contain the following operational definition of streeting: "# **Streeted**: The person was released. For example, a person who is brought in under ECO, who meets [TDO] criteria, but has to be released from custody at the expiration of the ECO as there is no bed available." [Bold in original] Of the approximately 200 people "streeted," not all were detained pursuant to an ECO for evaluation under TDO criteria.

[10] §37.2-808 B. …"to determine whether the person meets the criteria for temporary detention, a temporary detention order if it appears from all evidence readily available, including any recommendation from a physician or clinical psychologist treating the person, that the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

regarding ECOs, TDOs, and their outcomes are not collected in a consistent format at each CSB and, therefore, the OIG is cautious about interpreting this material; however, notwithstanding that caution, it is unquestionable that, during the last twelve months, scores of individuals were denied access to a secured mental health treatment setting under a TDO because an appropriate bed – and a willing provider – were not available.

While there are variations in causes and frequency of this denial of access across the regions, there were sufficient numbers in each region for the OIG to conclude that *streeting* is a state-wide problem in the Commonwealth. Cases that satisfy the HPR V definition of “streeted” vary in complexity and level of risk and the OIG received anecdotal reports from around the state. One such case is profiled below:

> This case involved a 66 year old female who was very delusional and paranoid. The woman was brought to Emergency Services on a weekday at approximately 6:00 p.m. for psychiatric evaluation after attempting to choke an intellectually disabled relative. The woman, in her delusional state, believed that the other individual was trying to kill her and that she was reacting in self defense.
>
> Emergency services personnel contacted 15+ private providers across the state in an effort to secure services under a TDO. None of these hospitals reported that they had an open appropriate bed. Two state facilities were contacted; one denied admission because the facility does not accept TDOs and the other denied admission because they do not accept persons over the age of 65. With no possibility of obtaining a TDO bed, the individual was released from custody and transported home by the Sheriff’s Department. The person’s relative was removed from the home to decrease the risk of homicide, but this fragile and vulnerable individual was left alone overnight.
>
> The following day emergency services made further contacts in an effort to secure a willing treatment facility for this deteriorating individual, but discovered that after multiple calls a TDO bed was still not available. Although not ideal, emergency services contacted a crisis stabilization unit in another catchment area, who agreed to take the person as long as she was medically cleared for their setting. Staff decided this was a better option than returning the person to her home to be alone for an additional night.
>
> Two trained staff members accompanied the person to the local hospital for medical clearance and then transported her to the crisis stabilization program, approximately 100 miles away, only to have her denied upon arrival because the person was lethargic from PRN medications she had received during the

medical clearance process. This left the person and the two staff members without options and a considerable distance from the home community.

The person's need for treatment and deteriorating status was very apparent to the accompanying staff members, so it was decided to transport her to yet another emergency room of a hospital in the area of the crisis stabilization program in an effort to either obtain a bed or get her medically cleared again so that admission to the crisis stabilization program might occur. The person was admitted to a medical unit at that facility. The entire process took more than 48 hours.

Unfortunately this case was not unlike other cases noted in the information provided the OIG, but thanks to the persistence of emergency services personnel, this individual was kept safe during this period. The record reflects that emergency services staff around the state routinely go far beyond reasonable expectations to keep clients as safe as possible despite sometimes daunting obstacles.

According to community services boards' emergency services personnel, some drivers that cause a person to be *streeted* instead of TDO'ed include:

- Private providers are reluctant to admit patients if there is a likelihood that an intermediate care bed at a state facility might not be available when needed, such as at ESH over the past year, because the private providers are obligated to provide care for patients who will be unable to pay for the extended services after the usual 10 to 20 days of allowed insurance coverage for "acute" care services is exhausted.

  Unfortunately, private facilities in the Tidewater area over the past year have had a number of individuals remain in their acute care settings for extended periods, even in some cases beyond 60 days, which underscores the fiscal caution of providers.

- Even though CSBs have contractual relationships with private providers to serve individuals under a TDO, local CSBs lack the authority to insist that a private facility admit an individual in crisis.

- Not all state-facilities will accept a person under a detention order and as a result not all state facilities function as a safety net for these individuals.

- As in the case cited above, non-medical personnel in crisis stabilization programs can make a determination of perceived medical stability and refuse care even though clearance had been made by fully authorized medical professionals.

- Private providers are also reluctant to admit persons with significant histories linked to past “treatment failures,” including resistance to care, significant behavioral challenges that create a risk of potential disruption to the facilities treatment environment and concern that the individual will most likely need extended services.

- In Hampton Roads, people are sometimes *streeted* when there are acute care beds available in local psychiatric facilities, but the private providers decline an admission for reasons unrelated to actual bed availability. The OIG has anecdotal reports that, despite the availability of a facility bed, some of the most acute individuals may be deemed too high risk and turned away.

- Emergency services personnel are often left with trying to “patch together” other creative treatment options in an effort to assure safety of the person and others.

- CSB emergency services personnel often call 15+ private providers in an effort to secure a bed, many of which are outside of the normal catchment area for the CSB and create a transportation issue for local law enforcement if a bed is eventually secured or persons evaluated as at risk are returned home with no immediate care.

- The OIG was informed that it was not unusual for individuals to remain in a local emergency room for periods in excess of 24 hours in hopes that a bed can be secured. This occurs because neither the CSB nor the emergency room staffs advise the detained individuals of their right to leave because of their ongoing clinical concerns for the person’s safety.

- CSB staff also acknowledged that when warranted, charges are placed against individuals for whom a bed can not be found because at least the jail provides a secure setting.

As one of only two mental health services mandated by the *Code*, the Virginia General Assembly (GA) has given considerable attention in the past to the process of securing and carrying out emergency services for citizens of Virginia who may be at-risk to self or others due to their mental illness. The GA renewed its focus on emergency services following the tragic deaths at Virginia Tech in 2007, which resulted in several changes in the delivery of emergency services in Virginia.

§§ 37.2.808-809 of the *Code of Virginia* outlines the process for temporarily detaining individuals in Virginia for the purpose of emergency clinical assessment towards a determination of risk/safety and treatment necessity due to mental illness. In practice, there are two ways that the process is initiated. These include the issuance of an emergency custody order (ECO) and a temporary detention order (TDO). Following are brief descriptions of each pathway:

1. If the process is initiated with an ECO, the *Code of Virginia* requires that a person detained for the purpose of being evaluated by a certified mental health professional "shall remain in custody until a temporary detention order is issued, until the person is released, or until the emergency custody order expires." An ECO is considered valid for up to four hours, unless after a finding of "good cause" by a magistrate the order is extended for a second period of two hours. The *Code* further requires that if an ECO is not executed within the time specified, the order is considered void and is to be returned unexecuted to either the office of the clerk of the issuing court or to a magistrate serving the jurisdiction of the issuing court.

2. The process may also begin with a TDO, without an ECO preceding the order. Section 37.2-809 of the *Code* indicates that a magistrate may issue a TDO upon the advice of, and only after an in-person evaluation by, a person skilled in the diagnosis and treatment of mental illness determines that "*the person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.*"

   The *Code* clearly places the responsibility of locating a secure setting or facility of temporary detention on the community services board. The *Code* requires that "*if a temporary detention order is not executed within 24 hours of its issuance, or within a shorter period as is specified in the order, the order shall be void and shall be returned unexecuted to the office of the clerk of the issuing court or, if the office is not open, to any magistrate serving the jurisdiction of the issuing court.*"

Time limits are established in the *Code* to assure the rights of individuals from unlawful detention are maintained. It is important to balance the rights of the person against an effort to protect these individuals, their families, and the public from harm due to mental illness, which emphasizes the importance of having adequate resources so that individuals can access the necessary care in a timely manner.

To assist the OIG in preparing to investigate the 2007 critical incident at VA Tech, Kent G. McDaniel, MD, PhD, then-consulting psychiatrist to the OIG and a member of the investigation team, developed a common framework for examining the assessment and intervention aspects of the commitment process relevant to that case. Dr. McDaniel's words are as valid, when addressing the current *streeting* concern, as they were in 2007. He emphasizes that:

> …one of the most important aspects of crisis intervention in a psychiatric emergency is assessing for safety. The Virginia Code has established that if there is evidence that there is a substantial likelihood that an individual in the near future is a danger to self or others due to mental illness, or is substantially unable to care for self due to mental illness, then legal action can be taken to ensure safety until a thorough assessment of dangerousness can be completed.[11]

As noted above, ECOs and TDOs are the legal vehicles that "ensure safety." Dr. McDaniel offers the following profound observations concerning psychiatric emergencies:

> Events that occur at the time of a psychiatric emergency can, and typically do, have life-long effects upon the individual. Effective interventions at the time of a psychiatric emergency not only ensure safety, reduce suffering, and mitigate the deterioration of adaptive functioning occurring at the time of the immediate crisis, but effective interventions also encourage the individual to resolve the crisis positively toward a more adaptive lifestyle. Intervention strategies can be considered ineffective when they do not ensure safety, reduce suffering, mitigate the deterioration at the time of the immediate crisis, or fail to promote healthier life choices. In short, interventions at the time of a psychiatric emergency are not only a means to ensure safety, but are often the pivotal means to engage or re-engage the individual into a process of recovery that promotes the future welfare of the individual and his or her role within the community."[12]

To deny individuals an opportunity to receive the level of care deemed clinically and legally necessary places each person at risk not only at the time of the immediate crisis but may create subsequent avoidable risk for the person, their family, and the community.

Streeting represents a failure of the Commonwealth's public sector safety net system to serve Virginia's most vulnerable citizens and places these individuals, their families, and the public at-risk. The fact that approximately 200 individuals, who were evaluated by skilled clinicians and determined to be a danger to themselves or others and lacking the capacity to protect themselves, were denied access to a secure environment for temporary detention and further evaluation, greatly concerns the OIG. We will monitor this issue going forward and make recommendations to end this questionable practice. The OIG hopes that one day the term *streeting* will pass from the lexicon of Virginia's behavioral health system.

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[11] OIG Report No. 140-07, *Investigation of April 16, 2007 Critical Incident At Virginia Tech*, Attachment C, pgs. 32-33.

[12] *Supra*.

EASTERN STATE HOSPITAL:

DOWNSIZING AND THE IMPACT ON HAMPTON ROADS: As a follow-up to the November 2010 review of the impact of the downsizing of ESH on Hampton Roads [OIG Report No. 197-10], the OIG has been reviewing data accumulated by the region's Facility Management Committee, tracking the clinical course for the persons denied admissions to the facility after being determined clinically appropriate for intermediate inpatient services, and surveying Emergency Services Directors in the region's nine CSBs.[13] While a small number of civil admissions (seven in four months) have occurred, the majority of the region's emergency services directors reported little relief to the dilemma created by the lack of bed availability at the region's state-operated facility.

As of March 31, 2011, ESH's census was 153 persons, in the 150 bed adult behavioral health unit, and 8 individuals still occupying the obsolete Building 24. The facility has been unable to discharge patients into community based programs because the needed community capacity has not been created. CSB emergency services staff report that, in order to have someone admitted to ESH, the hospital must first discharge a current CSB client from ESH – the so called "bed replacement system."

The bottom line is that, as of March 31, 2011, ESH remains unavailable as a safety net for most Hampton Roads residents requiring intermediate care in a secure state behavioral health facility As a result, some unknown number of people will receive inadequate care until regional intermediate care capacity is expanded or new community-based programs are created.

The new facility director, Jack Wood, has been working with the CSBs to create capacity through increasing active discharge planning efforts; however, the majority of CSB emergency services directors reported that the beds made available through this process were often used to admit forensic admissions that were waiting in jails and other forensic settings for court-ordered services to occur. There have been 32 forensic admissions in the past four months with 30 discharges occurring in the same period.

THE CERTIFICATION OF HANCOCK GERIATRIC TREATMENT CENTER: The Hancock Geriatric Treatment Center of ESH has been approved by Virginia Department of Health's Office of Licensure and Certification for the Medicaid program and has reestablished its certification to participate in the Medicaid program effective March 14, 2011. This means that ESH can once again receive federal payment for its 150 geriatric beds.

[13] According to the HPR V Emergency Services Managers, over 40 consumers received "inadequate care" last year because ESH was not available to provide intermediate care to stabilize the region's most fragile individuals with serious mental illness.

ENVIRONMENTAL RISK ASSESSMENT: The OIG discussed an on-going environmental risk factor with DBHDS in March following an environmental safety update conducted by the OIG for the Hancock Geriatric Treatment Center. This potential risk for self-harm by residents has been active for over a year at this facility. Reviews by two different teams cautioned the facility that changes were needed in the environment to assure the safety of persons served. The OIG was informed that this issue will be taken under review by the new facility director and the OIG informed of planned changes.

QUALITY MANAGEMENT OF COMMUNITY-BASED RESIDENTIAL PROGRAMS:

During the period covered by this SAR, the OIG has responded to serious complaints at two large community-based residential programs. Fortunately, the DBHDS's Office of Licensing was fully engaged and aware of the issues at these two residential facilities and, subsequently, the Department took appropriate action to assure compliance with pertinent regulations; however, it is unrealistic to expect the Office of Licensing to drive quality improvement in community-based residential programs.

In the years ahead, the individuals served by the Commonwealth's training centers and behavioral health facilities will increasingly reside in community based settings, and the OIG is concerned that the state currently lacks a coherent system to assure quality management of community-based programs. The U. S. Department of Justice (DOJ) shares our apprehension and noted its concern in the recently received letter containing its findings of the investigation of CVTC and recommendations for remedial action:

> The Commonwealth should ensure that its quality management systems are sufficient to reliably assess the adequacy and safety of treatment and services provided by community providers, the CSBs, and CVTC. The systems must be able to timely detect deficiencies, verify implementation of prompt corrective action, identity areas warranting programmatic improvement, and foster implementation of programmatic improvement.[14]

The OIG echoes DOJ's concerns because, during the next decade, thousands of individuals will be either discharged from the state facilities or living in community programs under an expanded waiver program and many new programs will be created, or existing programs expanded, to accommodate the increased demand.

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[14] U. S. Department of Justice letter of February 10, 2011 styled: *Investigation of the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center,* pg. 18.

Accordingly, in collaboration with the DBHDS, the OIG will design and conduct a comprehensive statewide survey of existing community based residential programs later this year to examine the quality performance of current residential models and make recommendations to create a robust person-centered quality management system that will act as an early warning system to identify (and correct) poorly operated programs and to drive quality improvement among thriving community providers.

REPORTS ISSUED THIS REPORTING PERIOD

During the period covered by this SAR, the OIG issued two reports: one inspection and one review. These reports cited below may be found on the OIG website at www.oig.virginia.gov:

- OIG Report No.195-10, Inspection of The Pines (Crawford Campus) Portsmouth, VA.
- OIG Report No. 197-10, A Review of the Downsizing of Eastern State Hospital and the Impact on Hampton Roads

FINDINGS AND RECOMMENDATIONS FROM REPORTS PUBLISHED DURING THIS SEMI-ANNUAL REPORTING PERIOD

OIG Report No. 195-10: *Inspection of The Pines (Crawford Campus) Portsmouth, VA*

OIG Findings: The record reflects a history of chronic noncompliance with licensure regulations at the Pines going back many years. These problems culminated in a 2009 recommendation by the DBHDS Office of Licensing that the facility be issued a Provisional License; however, the Commissioner of DBHDS, along with the Secretary of HHR, reportedly countermanded Licensing's recommendations. Instead of a Provisional License, a *Memorandum of Agreement*, detailing the remedial actions agreed to by Psychiatric Solutions, Inc. (PSI), was created to document the proposed corrective measures. Despite the *Memorandum of Agreement*, the violations at The Pines persisted.

In late-November 2009, the Director of the Office of Licensing met with the leadership of The Pines, and PSI's Regional Director, and candidly described the numerous systemic deficiencies and the consequences if this facility did not promptly bring its operation into compliance with the regulations. Most of the violations were repeat issues centering on key program components such as staffing patterns, staff training, important documentation, active treatment initiatives, improper handling – and notifications – of serious incidents, and repeated evidence of an unsafe physical environment.

Starting in November, DBHDS licensing specialists reportedly dedicated more than 450 hours to monitoring PSI's progress and determined that, by the end of February 2010, sufficient progress had been made to merit an annual license for this facility. Inasmuch as

PSI's license expired at the end of November, the facility was operating pursuant to a routine six-month *Good Standing* status from November 2009 until April 2010. The Office of Licensing subsequently granted The Pines an unqualified annual license (No. 909-14-003) effective March 1, 2010 that expired on February 28, 2011.

PINES UPDATE: The Pines Portsmouth campus's (Crawford, Brighton, & Kempsville) have been placed on provisional licenses effective April 25, 2011, and have entered into an Agreement with the DBHDS to implement an extensive Corrective Action Plan. According to the Agreement, failure to adhere to the Corrective Action Plan may result in forfeiture of this provider's license.

OIG Report No. 197-10: *A Review of the Downsizing of Eastern State Hospital and the Impact on Hampton Roads*

Finding No. 1.A: Many citizens from HPR V who were assessed and deemed clinically appropriate by DBHDS' regionally authorized Facility Management Committee (FMC) have not had access to the involuntary intermediate level of care provided by ESH for much of 2010.

Finding No. 1.B: ESH's admissions moratorium meant that some currently unknowable numbers of Hampton Roads residents were unable to access the full range of public sector safety net services.

Finding No. 1.C: A December 1, 2010, review by the FMC determined that 8 residents from the Tidewater area appearing on the original waitlist were at imminent risk and could benefit from more intensive services.

Recommendation No. 1: (Findings A-C): In order to assure the overall health and safety of the individuals recently identified by the FMC as at-risk, the OIG recommends:

A. That the Department maintain and sharpen its focus to assure that each person on the current waitlist be provided access to the appropriate level of care, including access to state-facility intermediate care, when the FMC and the CSB determine that admission is deemed to be clinically appropriate.

B. That the Department provide the OIG with a written strategy outlining steps to address the admissions/discharges at the facility until the current situation has abated. This plan should be forwarded by February 28, 2011.

C. The OIG requests that FMC provide a list of persons who were denied admission to ESH's adult behavioral unit this year, after the FMC screened and approved their civil admission to the state facility, and to monitor these 30 individuals until March 15, 2011.

Finding No. 2: The current capacity and array of community services in HPR V is inadequate to serve Hampton Roads residents. ESH, in its downsized configuration, has been overwhelmed by a demand for admissions exceeding its reduced bed capacity.

Recommendation No. 2: That the DBHDS, in collaboration with the HPR V CSBs, explore the specific combination of community services and supports that would have been needed to serve the residents of Hampton Roads to support these individuals and avoid an involuntary civil commitment to ESH.

Finding No. 3.A: The current crisis was triggered by the confluence of historically inadequate facility leadership, the loss of operating beds at ESH resulting from the downsizing initiative, $2.6 million in community funding that was not appropriated in 2009, the absence of a meaningful response by DBHDS to the repeated petitions from local governments and CSBs during 2008 and 2009, and the inability to create essential community capacity before obsolete ESH buildings were removed from service and patients transferred into the new downsized facility.

Finding No. 3.B: The new adult behavioral health unit at ESH has 85 fewer adult beds than were operational in August 2009, and this relatively abrupt bed reduction that was not supported by community funds has overwhelmed both ESH and the HPR V's regional capacity to provide an adequate facility safety net, including access to the state facility for its residents meeting ESH admission criteria.

Finding No. 3.C: Unlike other adult populations, there is no state-operated facility safety net back-up system established for adults with serious mental illness in the Tidewater area who need involuntary intermediate care or extended care services.

Finding No. 3.D: HPR V does not currently provide an involuntary intermediate level of care in the community comparable to the services provided by ESH. Until the same level of care is available in community-based services, the denial of admission to the facility represents a failure to assure that a full array of safety net services is available in Hampton Roads.

Recommendation 3 (A – D): That the Commissioner of the DBHDS, in collaboration with the State Board, review these *Findings* and determine if any revisions are required to Virginia's existing safety net policies for persons with serious mental illness.

Finding No. 4: As of November 2010, 37 patients at ESH were ready for discharge, but remained in the state hospital because there were no suitable community placements available to receive these individuals.

Recommendation No. 4: That, with all possible dispatch, the DBHDS seek funding to create the community based-services necessary to move the individuals on ESH's discharge ready list into supported community settings.

Update: In a December 17th press release, Governor McDonnell proposed an increase of $2.4 million "to increase targeted community behavioral health services in the Tidewater/Eastern State Hospital region, including: Sponsored Placements, Local Inpatient Purchase of Services (LIPOS), Expanded Discharge Assistance Program, and Stabilization and Competency Restoration in Community Hospitals."

Fast tracking these funds will allow HPR V to create the community capacity to relieve the admissions/discharge pressure on ESH, and allow the hospital to find suitable placements for the approximately three dozen current residents who could be returned to their community if services were available.

Finding No. 5.A: During 2008 and 2009, the local governing bodies and CSBs of HPR V requested that the Commonwealth not downsize ESH without creating the community capacity to accommodate the people who previously would have served by ESH.

Finding No. 5.B: That *Code* Section 37.2-316 requires a consensus planning team be established before a facility is restructured or closed, but that this provision historically has not been deemed applicable to the downsizing of a state facility.

Recommendation No 5: That in planning for future initiatives to take one or more residential units of a state facility offline, the DBHDS will involve the CSBs within the region in the planning efforts to achieve this outcome and notify the State Behavioral Health & Developmental Services Board and the Office of Inspector General of its intent to carry out this action and provide periodic updates to the downsizing plan.

OIG REVIEW OF THE DBHDS' CREATING OPPORTUNITIES PLAN

The OIG's last Semiannual Report noted that "The *Creating Opportunities Plan* is likely the most consequential document created by the DBHDS in a generation." In addition to breaking-down traditional silos and rationalizing the system of care, the greatest promise of this effort lies in the continued commitment to aligning the person-centered and community-focused system of care initially envisioned in the Department's *Strategic Plan* with the services actually delivered. The promise of that realization was echoed by Governor McDonnell in his budget submission and the final budget approved by the General Assembly.

This alignment of vision and resources presents a moment of great promise and great responsibility for DBHDS, service providers and the advocacy community. Realizing the promise of a community-focused system of care that is person-centered at each point of service delivery will require continuous dialogue with those who receive these services, or are expected to benefit from the reforms, and objective review of the community-focused services that are eventually implemented.

Ultimately, the OIG's Mission is to protect the health and welfare of individuals receiving services in our state facilities and other licensed providers throughout the Commonwealth. This is necessarily a person-centered undertaking and our commitment is to listening to the voice of service recipients and listening to the voice of the many providers who are relied upon to deliver services, understanding that person-centered values cannot be fully realized unless they are embedded in the system of care providing the services.

To date, OIG staff has participated in each *Opportunities Plan* Workgroup meeting held from February 1, 2011 through April 15, 2011, reviewed recommendations now being considered by the Commissioner, and established communication linkages with 39 behavioral health and developmental services advocacy organizations. In the coming months, OIG staff will actively review services the Department ultimately implements from the various Opportunities Plan Workgroup recommendations and we will share feedback with DBHDS leadership in hopes of supporting successful outcomes.

OIG REVIEW OF FORENSIC SERVICES:

In February, OIG staff began a review of facility-based forensic services, focusing on the extent to which individuals receive forensic services that reflect the Department's values of person-centeredness and recovery. To date, OIG staff has conducted facility reviews at four of the seven behavioral health facilities. Review of the three remaining facilities is expected to be concluded by the end of May.

The DBHDS "Opportunities Plan" includes a dedicated focus on the broad issue of Behavioral Health Facility Effectiveness & Efficiency. This work is expected to bring forward recommendations for significant changes in many areas, including improved effectiveness and efficiency in the area of forensic services. The OIG will share feedback from our review with DBHDS leadership in hopes of supporting successful outcomes in this challenging area of behavioral health services.

BACKGROUND: DBHDS provides forensic services in each of the Department's seven adult behavioral health facilities. In FY 2010 these facilities provided forensic services to 1,165 individuals and the average daily census for the forensic population was 469, or 36% of the total inpatient population. The forensic population utilized 171,073 bed-days in the seven facilities in FY 2010. The growth in forensic bed utilization since 2005 has been cited as a contributing factor to facilities having fewer civil beds for treatment of individuals needing extended crisis or rehabilitation services.

The forensic service area presents unique challenges and risks for DBHDS. Individuals classified in any of the five forensic categories noted below have stakeholders from the law enforcement, corrections and judicial community that must be satisfied with the services provided. As such, there is a high degree of concern over potential clinical errors, care

coordination problems, adverse public safety outcomes and legal challenges from judges, prosecutors and defense attorneys.

Forensic staff and agency leadership recognize that any perceived shortcomings in meeting the expectations of the courts or the public can easily provoke legal action and negative publicity for the Department and the Executive Branch. This creates an environment of risk that exceeds other populations treated in DBHDS facilities. The environment of risk creates additional challenges for DBHDS to provide forensic services in a manner that reflects their commitment to person-centeredness and recovery, foundational values that have a positive impact on treatment outcomes for all populations.

Forensic Populations: Individuals can receive DBHDS forensic services within five categories. The OIG obtained census information within each of these categories as of March 31, 2011, the end date of this SAR report period.

Persons Requiring Emergency Treatment Prior to or After Trial (§ 19.2-169.6) - A person with criminal charges, or who is awaiting sentencing or serving a sentence in a local correctional facility, may be admitted to an inpatient facility for emergency treatment upon a finding of probable cause that he/she has a mental illness, and that there exists a substantial likelihood that he/she will, in the near future, cause serious physical harm to self or others as a result of that mental illness (inability to care for self is not an available prong for commitment under this statute). Population as of 3/31/2011: 24

Evaluations of Competency to Stand Trial and Sanity at Time of Offense (§§ 19.2-169.1 and 19.2-169.5) - These evaluations allow a maximum 30-day inpatient stay. For persons believed not to be competent, restoration treatment may be ordered. Population as of 3/31/2011: 6

Restoration to Competence to Stand Trial (§ 19.2-169.2) - After undergoing an initial evaluation of competence to stand trial, some defendants are adjudicated incompetent and ordered to undergo treatment to restore competence. These renewable orders are for up to six months of treatment (except for a small handful of misdemeanor charges, which can limit restoration to 45 days). Population as of 3/31/2011: 78

Mandatory Parolees (§37.2-814 et. seq.) - These individuals are admitted directly from the Department of Corrections as civilly committed persons upon the expiration of their sentences. Population as of 3/31/2011: 9

Not Guilty by Reason of Insanity Acquittees (§ 19.2-182.2 and 19.2-182.3) - These individuals are admitted first for an evaluation period of 45 days, after which about 80% are committed to the custody of the Commissioner, a renewable commitment that lasts for one year (misdemeanant acquittees are limited to one year of commitment as an NGRI acquittee, but can then be civilly committed if necessary). After commitment, NGRI acquittees can gradually obtain privileges that integrate increasing levels of community

access, until they are considered appropriate for conditional release. Population as of 3/31/2011: 279

OIG MONITORING OF THE U. S. DEPARTMENT OF JUSTICE INVOLVEMENT AT CENTRAL VIRGINIA TRAINING CENTER AND THE OTHER STATE-OPERATED TRAINING CENTERS

The 30-month investigation by the Department of Justice (DOJ) of the Commonwealth's compliance with the Americans with Disabilities Act (ADA) and the findings based on DOJ reviews at Central Virginia Training Center (CVTC) culminated in a letter issued on February 10, 2011. As summarized in the letter, the DOJ found the following:

> *We have concluded that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation with the ADA. The inadequacies we identified have resulted in needless and prolonged institutionalization of, and other harms to, individuals with disabilities at CVTC and in other segregated training centers throughout the Commonwealth who could be served in the community.*
>
> *Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration will permit the Commonwealth to support people with disabilities in settings appropriate to their needs in a more cost effective manner.*

The DOJ findings letter also contained a number of remedial measures that are to be assumed by the state in order to avoid additional action by the DOJ. Among the remedial measures are the following:

<u>Community Capacity</u>

- *The Commonwealth must increase community capacity by allocating additional waivers and expanding community services to serve individuals in or at risk of entering the training centers.*
- *As the State downsizes its institutional population, the State should realign its investment in services for individuals with intellectual and developmental disabilities away from institutions to prioritize community-based services.*
- *The Commonwealth should develop crisis services; preserve the respite services it is providing; and provide integrated day services, including supported employment while moving away from its reliance on sheltered workshops.*

- *The Commonwealth should ensure that its quality management systems are sufficient to reliably assess the adequacy and safety of treatment and services provided by community providers, the CSBs, and CVTC.*[15]

Discharge Planning

- *The Commonwealth must implement a clear plan to accelerate the pace of transitions to more integrated community-based settings and overcome what has become an institutional bias in its system.*
- *The Commonwealth should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process.*
- *The Commonwealth should make all efforts to prevent new admissions to the training centers, including expanding community services necessary to divert individuals and stabilize them in the community.*[16]

The OIG continues to monitor DBHDS' response to the DOJ review at CVTC and the system's on-going efforts to address issues identified by the DOJ experts during their on-site visits. Continued monitoring efforts include reviewing CVTC's compliance with its action plan, participating in telephone conference calls between the facility, the department, and DBHDS consultants, and reviewing progress made by DBHDS in addressing broader systemic recommendations.

The DOJ letter of February 2011 does not reflect the seriousness with which DBHDS and the current administration have acted in proactively developing and implementing strategies for resolving the issues identified by the DOJ experts during their on-site visits in 2008 and 2010, as well as previous recommendations made by the OIG. DBHDS has made considerable progress on concerns raised by both the DOJ and the OIG.

Governor McDonnell has also shown his commitment to invest in the lives of the persons served by the entire DBHDS system through his recent budget proposals. While the challenges are significant, the DOJ's findings letter acknowledged the Governor's and DBHDS's efforts and expressed a desire to work with Virginia officials in moving forward in serving the persons with intellectual disabilities in the most integrated setting appropriate to the needs of the individual. A negotiated settlement between DOJ and the Commonwealth is expected this summer.

[15] *Supra*,

[16] *Supra*, pg. 19

CVTC ACTION PLAN:

CVTC has been working diligently on its plan of continuous improvement for achieving best practices within the facility in key areas such as active treatment, discharge planning, and coordinated person-centered services across disciplines. This plan, which was designed primarily to address the issues identified by the DOJ, provides a roadmap of objectives and activities.[17] The comprehensive approach undertaken by the facility strives to link service provision with the key provisions of the *Americans with Disabilities Act* and the *Olmstead Decision*. CVTC has made considerable progress, with the aid of their consultants and DBHDS leadership, in creating pathways between the individualized services and supports provided to each resident and ongoing quality improvement and risk reduction initiatives.

DBHDS's DOJ expert consultants, H&W and Bailey & Associates, completed an annual monitoring visit to CVTC in January 2011, and noted progress in several areas, including the integration of behavioral and psychiatric services into the overall services and supports planning process, the development of quality assurance processes and an increased focus on risk management.

SYSTEMIC ACTION PLAN:

DBHDS' ID leadership has moved forward to make systemic changes designed to assure consistency with DOJ objectives across the state-operated training centers. Progress to-date includes the following:

- DBHDS developed two new positions to provide additional oversight to its DOJ compliance process. The positions, Training Center Operations Manager and Family Resource Consultant, were filled within the last six months.
    - The Training Center Operations Manager has been tasked with overseeing and monitoring CVTC's improvement efforts, monitoring national DOJ trends, and assisting the other training centers in making improvements as they relate to the DOJ.
    - The Family Resource Consultant position will focus on and facilitate the education of families about community options.

- DBHDS published its revised *Admissions and Discharge Protocols for Persons with Intellectual Disabilities Residing in Commonwealth of Virginia Training Centers*. The updated protocol is designed to improve standardization across all five training centers.

[17] The areas identified by the DOJ during their on-site reviews at CVTC in 2008 and 2010 are outlined in the OIG Semi-Annual Report for the Period of April 1, 2010 to September 30, 2010.

  - The protocol delineates the role of the training centers and the CSB support coordinators, formerly case managers, in facilitating discharge planning.
  - The protocol includes a "Supports for Living" form that guides the partnership between facility staff, the individual, family member or authorized representative, and the CSB support coordinator in identifying barriers to discharge.
  - The revised protocol also requires more active engagement between CSB Support Coordinators and training center staff.

- DBHDS completed regional training sessions on the updated protocols during January and February 2011.
  - A broad group of participants were involved in the training including training center social workers, CSB ID directors and Support Coordinators, Community Resource Consultants, and other stakeholders.

- DBHDS' Training Center Operations Manager will coordinate assessments of the discharge process at each training center and assure compliance with the new protocols beginning in April 2011.
  - The assessment will be completed by a team composed of the Training Center Operations Manager, the Family Resource Consultant, and the Community Resource Consultant for that region.
  - The assessment will include discussions with social workers, social work directors, CSB ID Directors, and CSB ID case managers to determine what resources are needed to streamline the region's discharge process.
  - The assessment team will also examine the ISP planning process and the quality monitors established by each facility.

- DBHDS' Family Resource Consultant has initiated a plan for actively educating individuals and their families regarding community living arrangements and will assist facility staff and support coordinators in addressing family concerns regarding community placement.

SIGNIFICANT OUTSTANDING FINDINGS AND RECOMMENDATIONS (FROM PAST OIG REPORTS)

Section 37.2-425.A.3 of the *Code of Virginia* requires that the OIG identify in its Semi-Annual Report, each significant recommendation on which corrective action has not been completed. Not all reports generated by the OIG are classified as public documents; investigations that focus on the care of specific individuals or the actions of personnel are considered *Confidential Governor's Working Papers* and not placed in the public domain. Active findings from previous reports have been briefly summarized in this section in order to provide areas of general concern. This section includes a summary of significant recommendations that remain active as of March 31, 2011.

Facility System

1. The Virginia Center for Behavioral Rehabilitation (VCBR) is a facility designed to provide treatment for previously incarcerated sex offenders who, after evaluation, are judged to present a danger to themselves and/or others requiring civil commitment for treatment following their release from the Department of Corrections.

   This program has presented long-standing concerns for the OIG. Past inspections by the OIG have consistently documented concerns at the facility including, but not restricted, to the following: limited treatment opportunities provided the residents; inadequate treatment planning; failed programming initiatives; and inadequate staffing to assure safety and effective programming. Ongoing concerns resulted in the 2008 OIG recommendation that a permanent advisory committee be established to provide consultative support to the facility's leadership team in making operational and programming decisions.

   The OIG was informed by DBHDS that the advisory committee has not met since the hiring of the new facility director in August 2010. While the change in leadership has resulted in some positive changes within this facility, not utilizing the advisory committee during this critical period of change is considered premature by the OIG.

   When the OIG conducted an unannounced visit at the facility in February 2011, the OIG was informed of other changes in the leadership structure that had occurred just prior to the visit, including the hiring of the Director of Healthcare Compliance whose responsibilities include the formation of quality improvement initiatives within the setting.

   During the February inspection, the OIG was unable to effectively evaluate programmatic changes at the facility because they had just been implemented. While the implemented programmatic changes were judged to be clinically appropriate for the treatment of this population, indicators for determining program effectiveness had not been established. This most recent change makes at least the third significant programmatic change within this setting since it began in 2003.

2. Eastern State Hospital (ESH) has been a priority for the OIG and the focus of attention for several years. Over the past year, the facility's Hancock Geriatric Treatment Center (HGTC) was decertified by the Centers for Medicare and Medicaid (CMS).[18] As a result of the decertification, there have been no new admissions to the HGTC for the past seven months. This, coupled with the lack of admissions to the adult unit for a period of

[18] CMS notified ESH that it was once again certified to receive Federal Medicaid and Medicare funding effective March 14, 2011.

at least ten months in 2010, created an undue hardship for the region's community services boards in accessing the appropriate level of care for persons in crisis and these issues were profiled in OIG Report 197-10, *A Review of the Downsizing of Eastern State Hospital and the impact on Hampton Roads.*

Although the crisis created by the lack of available beds continues to be an issue, the new leadership at ESH has addressed many of the outstanding recommendations during the past six months. Examples include the following:

2(a). Changes in incident management and the creation of a facility risk management plan have resulted in a more comprehensive approach to the documentation and analysis of areas of risk.

2(b). The recruitment and retention of qualified nursing personnel at Eastern State Hospital has been a long-standing issue for the OIG. Factors that were identified as creating dissatisfaction among nursing personnel included the use of overtime and line staff not being involved in facility decision-making. Initiatives created by the new leadership of the facility have resulted in changes designed to address these issues. The facility has made a change in nursing leadership, conducted a review of staff deployment, and initiated a process for addressing overtime. Staff involvement in decision-making activities has increased.

3. The Forensic Population: Issues that impact the delivery of forensic services has been the focus of a number of past investigations completed by the OIG and services to this population remains a concern because this population continues to be one of the fastest growing populations being served by the state-operated behavioral health facility system. Because of the often extensive treatment and conditional release process associated with the forensic population, civil beds become increasingly less available. Of the 29,634 bed days utilized in the state-operated facilities in December 2010[19] in the state-operated facilities, 43% were utilized by the forensic population.

   Outstanding OIG recommendations that center on the inherent safety risks of mixing persons with a severe mental illness with individuals with a primary personality disorder remain unresolved. This concern impacts both the adult and adolescent populations. In order to diminish the safety risks associated with the mixing of the forensic populations, the OIG recommended that options for expanding the use of outpatient assessment (e.g. jail-based) and evaluations be reviewed with the courts to allow for increased screening of defendants prior to inpatient treatment and that DBHDS explore

[19] Data from DBHDS Avatar system does not include the bed days utilized by the geriatric population.

establishing increased security measures for individuals referred by the courts for forensic evaluations.

Given the on-going concerns associated with this population and its forecasted growth, the OIG has undertaken a review of forensic services across the state-operated facility system. The results of this survey will be published later this year.

4. Filing Charges Against Persons: An investigation of a critical incident at one of the mental health facilities in 2009 resulted in the OIG conducting a preliminary review of facility practices regarding filing charges against persons while they are hospitalized. The review revealed there was significant variation in practice among the facilities regarding this issue. One behavioral healthcare facility, in particular, had a pattern of bringing charges against their patients that exceeded that of all the other facilities combined. In February 2011, DBHDS created a panel of clinical specialists to review the practice at the one facility.

   At the time of the 2009 review, the OIG recommended the revision of Departmental Instruction #205 (RTS) 89 *Filing Charges Against Patients or Residents*. The OIG was informed that findings from the February DBHDS review have been incorporated into the final draft of the DI and it has been submitted to the Office of the Attorney General for review. It is anticipated that this active recommendation will be resolved once the DI has been finalized and the appropriate staff training has been completed.

Community Studies

1. Crisis Stabilization Units: In 2009 the OIG conducted a review of residential crisis stabilization units (CSU) operated or contracted by the CSBs. Since the initial recommendations were made, DBHDS has been working with all of the CSUs to develop a detailed plan of improvement designed to resolve the issues identified. Efforts include the identification of target populations, admission criteria, performance expectations, and data requirements. DBHDS reported that a majority of CSUs have developed their improvement plan. Full implementation statewide is scheduled to occur by June 2011.

   Many of the CSUs lacked established mission statements and admissions criteria at the time of the review. It was determined that not all of the CSUs accept Temporary Detention Order (TDO) admissions. DBHDS planned on completing a review of best practices to include how to manage TDO admissions in the least restrictive setting possible while still maintaining safety. The OIG was informed that four CSUs currently take TDOs and another six anticipate that they can begin taking TDOs by June 2011. The remaining CSUs are evaluating specific studies to determine what types of supports and changes will be necessary to begin accepting TDO admissions.

DBHDS held a conference for CSU leadership and staff in the fall 2010 to provide a forum for all CSUs to share mutual experiences and resources, as well as discuss best practices that would maximize the benefits of the CSUs across the service system. Topics discussed included training needs, staffing patterns, peer support, medication management and screening forms. Service provision for persons with intellectual disabilities in crisis is also an area of concern that has been discussed.

Although considerable progress has been made to address the recommendations made by the OIG, the recommendations remain active. It is anticipated that the majority of the recommendations will become inactive following an OIG review of the pending completion of the comprehensive implementation plans by all the CSUs scheduled for June 2011.

2. CSB Emergency Services: Responses to outstanding recommendations to previous community studies regarding CSB emergency services, CSB mental health case management services and CSB substance abuse services were submitted to the OIG in March 2011. Progress in all areas of active recommendations was noted. As many of the issues identified by the OIG through past community studies' recommendations are being addressed by various *Creating Opportunities* implementation teams, the OIG has decided to make the outstanding recommendations inactive. Monitoring of recommendations by teams will be an ongoing activity of the OIG. An update of these activities can be found in this Report in the Section titled: *OIG Review of DBHDS' Creating Opportunities Plan*.

SUMMARY OF OUTSTANDING RECOMMENDATIONS: DIVISION OF DEVELOPMENTAL SERVICES

Facility System

1. The excessive use of overtime in one of the training centers operated by DBHDS was a concern identified by the OIG. Under new leadership, this facility has made commendable progress during the last six-months to right size its direct care staff workforce. The following are some recent initiatives:

    - The progress of the facility's initiative can be measured by the impressive reduction in the average number of overtime hours in the first quarter of calendar year 2011 (16,273/month), versus the average number of overtime hours (28,810/month) in the 3rd quarter of calendar year 2010 when the OIG's report was issued.

    - The time it takes for a new hire to become engaged in the provision of direct care services under supervision was reduced from 12 weeks to less than 6 weeks.

- 103 DSAs have been hired since Oct. 2010, with 25 more in the recruitment pipeline as of early April. Even with staff changes that have occurred, such as retirements, resignations and terminations, there has been a net gain of 46 DSAs, not counting the 25 in the hiring pipeline since this issue was initially identified.

- In Sept. 2010, an estimated 50 to 60 employees were working in excess 72 hours per week. Currently, no employee works more than 32 hours of overtime in a week except in a rare emergency.

- The "committed days" that DSAs were required to sign up for has been reduced from 12 in Sept. 2010 to 4 in March 2011.

It is anticipated that this active recommendation will be resolved during 2011 because of the initiatives undertaken by the current facility leadership.

2. In August 2009, the OIG investigated concerns regarding the delivery of dental services for one of the state-operated training centers. Because of the risks to the residents revealed during this investigation, the OIG recommended that DBHDS develop guidelines for dental services across the facility system, to include a number of elements such as: the scope of services to be provided; credentialing of service providers, including dental hygienists; expectations regarding assessment and treatment; expectations regarding the documentation of services, including informed consent; expectations regarding the role of dental services in the development of individualized habilitation plans; the establishment of quality indicators based on Standards of Care which are monitored both at the facility level and departmental level; and ongoing peer review process for chart audits. The guidelines have been delayed until DBHDS fills the Assistant Commissioner for Quality Improvement which is targeted for completion by summer 2011. In its most recent response to the OIG, DBHDS has targeted September 2011 for the completion of this important initiative.

OIG DATA MONITORING

A. Facility Data

Critical Incident Reports

Documentation of critical incidents (CI) as defined by *The Code § 2.1-817503* is forwarded routinely to the OIG by the DBHDS operated state hospitals and training centers. During this semi-annual reporting period, 440 critical incidents related to injuries and other areas of risk were reported to the OIG through the PAIRS database. Of these incidents, 215 (49%)

incidents occurred in the state-operated training centers and 225 (51%) occurred in the state-operated behavioral health facilities. The OIG reviewed each of the 440 critical incident reports forwarded by DBHDS with an additional level of inquiry and follow up was conducted on 79, or 18% of the CIs.

Quantitative Data

In order to refine the inspection process so that core risks could be monitored, a monthly facility report was instituted by the OIG. This report provides raw data on trends within facilities that might indicate a need for further clarification and onsite attention. Areas that are monitored through this monthly report include census, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect.

Monitoring of Deaths

The OIG receives reports from the Medical Examiner's office for all 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. There were 56 deaths in the state-operated facilities from 10/1/10 to 3/31/11; 18 of the deaths occurred in the training centers and 38 deaths were reported in the behavioral health facilities. All of the 35 autopsies forwarded by the Medical Examiner's office for this period were reviewed.

B. Community Critical Incidents

With greater emphasis on community-based services, the OIG initiated a preliminary review of the critical incidents reported to DBHDS' Office of Licensing beginning in January 2011. The purpose for this preliminary review by the OIG was to gain a more comprehensive understanding of the data collected by DBHDS and determine whether the information collected is used to facilitate systemic quality improvement initiatives in and across community-based services.

As outlined in its regulations[20], licensed providers are required to report to DBHDS allegations of abuse and neglect, deaths, serious injuries and other areas of risk. Critical incident reports are forwarded by the provider to their assigned licensure specialist. The licensure specialist reviews the critical incident reports for each of the programs they monitor. The information informs the licensing process by aiding each specialist in providing consultation to the program in a variety of key areas relevant to the provider's overall program of risk management.

[20] Chapter 105_RULES AND REGULATIONS FOR THE LICENSING OF PROVIDERS OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES, 12 VAC 35-105-160. C.1-3

Because of limited resources, the Office of Licensing does not review the incidents across the provider system. The OIG reviewed 810 critical incident reports; dividing each report into one of 15 categories developed by the OIG. The majority of the categories were modeled on those contained in the PAIRS reporting system that tracks a subset of critical incidents in the state-operated facility system related to injuries and deaths. Of the 810 incidents reviewed:

- 173 or 21% were incidents resulting in the use of restrictive behavioral interventions by staff;
- 154 or 19% were death reports;
- 103 or 12% involved falls with injuries; and,
- 94 or 11.6% involved incidents of peer to peer aggression.

Observations from this preliminary review were shared with the Director of the Office of Licensing. OIG observations included the following:

1. There was significant variation in the thoroughness and consistency of detail of the information provided on the incident report forms.
2. Even though the Office of Licensing provides a standardized form for use when reporting incidents, many of the providers use their own forms which will make future systemic data collection more challenging.
3. The variation in reporting points to an inconsistent understanding among the providers regarding reporting requirements.
4. A significant number, 65%, of incident reports regarding behavioral management were documented by a singular provider. The reports highlight a need for increased staff training regarding behavioral management. Through discussions with the Director of Licensing, it is evident that he has an understanding of the program's training needs and efforts are underway to support the program in increased staff awareness of positive behavioral supports.

The OIG will continue to monitor critical community incidents for at least the next six months. As a result of the preliminary review, the OIG recommends that DBHDS consider providing resources for creating a community incident database for tracking provider incidents across the community system. Information gleaned provided increased knowledge of systemic training needs, define areas of risk, and create dialogue regarding potential performance improvement initiatives.

C. Complaints and Requests for Information/Referrals

The OIG responded to 10 complaints and requests for information/referrals from citizens, service recipients, and employees. Of these contacts, 5 were complaints/concerns and 5 were requests for information/referrals.

REVIEWS OF REGULATIONS, POLICIES, AND PLANS

During this semiannual reporting period, the OIG reviewed and/or made comments on the following regulations, policies, plans and other documents:

Policies

- DBHDS State Board Policy 6005(FIN) 94-2, Retention of Unspent State Funds by Community Services Boards
- DBHDS State Board Policy 6002(FIN) 86-14, Services Availability and Ability of Client to Pay Philosophy
- DBHDS DI 401(RM) 03, Risk and Liability Management

Protocols

- Admission and Discharge Protocols for the State-Operated Training Centers

Plans

- State-Operated Behavioral Healthcare Facilities Recovery Plans (8 plans)
- DBHDS Performance Contracts (current FY11 and proposed FY12 contracts)

Other Documents

- Reports of areas of non-compliance and DBHDS plans of correction resulting from reviews conducted by the Centers for Medicare and Medicaid for the following facilities:
    - Eastern State Hospital
    - Southside Virginia Training Center
    - Southeastern Virginia Training Center
    - Northern Virginia Training Center

- Major Issues Facing the Commonwealth's Behavioral Health and Developmental Services System: James W. Stewart, III, Commissioner, DBHDS / January 13, 2011/ Joint Meeting of the Senate Education & Health Committee and the House Health, Welfare & Institutions Committee Virginia General Assembly

OTHER OIG ACTIVITIES

The OIG engages in a number of other activities, such as making presentations and serving on committees. Engagement in these activities results in increased knowledge of the system and allow for interaction of the OIG with state-level stakeholders. The following activities occurred during this semi-annual reporting period:

A. OIG staff made one presentation regarding the work of the office or served as the guest speaker;

- The Advisory Consortium on Intellectual and Developmental Disabilities (TACIDD)

B. Staff of the OIG participated in 6 conference and training events;

- Principles of Drug Addiction Treatment for Criminal Justice Populations
- Presenting Drug Abuse Among Children and Adolescents
- Dual Disorders Recovery Counseling
- VACSB Fall Conference
- VACSB Winter Conference
- Achieving Better Lives: Transitioning from Barriers to Support

C. The OIG participated in a variety of forums and on various committees that address issues relevant to mental health, intellectual disabilities and substance abuse and to state government;

- DBHDS Clinical Services Quality Management Committee
- DBHDS Systems Leadership Council
- Virginia Commission on Youth
- The Advisory Consortium on Intellectual and Developmental Disabilities
- DBHDS Creating Opportunities Teams
    - Emergency Response Implementation Action Team
    - State Hospital Effectiveness & Efficiency Implementation Team
    - Peer Service Infrastructure Implementation Team
    - Substance Abuse Implementation Action Team

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

- DBHDS central office staff
- DBHDS facility staff
- Service recipients and family members
- DOJ staff, DBHDS staff, and DBHDS consultants
- Office of the Attorney General staff
- Substance Abuse and Addiction Recovery Alliance (SAARA)
- National Alliance for the Mentally Ill – VA
- ARC of Northern VA
- Virginia Organization of Consumers Asserting Leadership (VOCAL)
- Virginia Hospital and Healthcare Association

This concludes the Semi-Annual Report of the Inspector General required by *The Code* § 37.2-425 covering the period October 1, 2010 to March 31, 2011.

If additional information about the contents of this *Report* is required, please direct inquiries to the below address, call (804) 692-0276, or fax questions to (804) 786-3400.

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Appendix 1

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

FEB 10 2011

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Patrick Henry Building, 3rd Floor
1111 East Broad Street
Richmond, Virginia 23219

Re: Investigation of the Commonwealth of Virginia's Compliance with the Americans with Disabilities Act and of Central Virginia Training Center

Dear Governor McDonnell:

We write to report the findings of the Civil Rights Division's investigation of the Central Virginia Training Center ("CVTC") and of the Commonwealth of Virginia's ("State" or "Commonwealth") compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999), requiring that individuals with disabilities receive services in the most integrated setting appropriate to their needs. Our investigation was conducted pursuant to Title II of the ADA, U.S.C § 12133, and the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional or federal statutory rights, including those under the ADA, of institutionalized individuals.

We write to provide you notice of the Commonwealth's failure to comply with the ADA and of the steps Virginia needs to take to meet its obligations under the law. 42 U.S.C. § 2000d-1 (incorporated by 42 U.S.C. § 12133). This letter also serves as formal notice under CRIPA of the findings of our investigation, the facts supporting them, and the minimum steps necessary to remedy the deficiencies. 42 U.S.C. § 1997b(a). The Commonwealth's implementation of the remedies discussed in this letter will correct the identified deficiencies in its compliance with the ADA, fulfill its commitment to individuals with disabilities, and protect the public fisc.

I. SUMMARY OF FINDINGS

We have concluded that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA. The inadequacies we identified have resulted in the needless and prolonged institutionalization of, and other harms to, individuals with disabilities in CVTC and in other segregated training centers throughout the Commonwealth who could be served in the community. Systemic failures causing this unnecessary institutionalization include:

- The Commonwealth's failure to develop a sufficient quantity of community-based alternatives for individuals currently in CVTC and other training centers, particularly for individuals with complex needs;
- The Commonwealth's failure to use resources already available to expand community-based services and its misalignment of resources that prioritizes investment in institutions rather than in community-based services; and
- A flawed discharge planning process at CVTC and other training centers that fails to meaningfully identify individuals' needs and the services necessary to meet them and address barriers to discharge.

The Commonwealth also places individuals currently in the community at risk of unnecessary institutionalization at CVTC and other training centers, in violation of the ADA. Systemic failures causing this violation include:

- The Commonwealth's failure to develop a sufficient quantity of community services to address the extremely long waiting list for community services, including the 3,000 people designated as "urgent" because their situation places them at serious risk of institutionalization; and
- The Commonwealth's failure to ensure a sufficient quantity of services, including crisis and respite services, to prevent the admission of individuals in the community to training centers when they experience crises.

Reliance on unnecessary and expensive institutional care both violates the civil rights of people with disabilities and incurs unnecessary expense. Community integration will permit the Commonwealth to support people with disabilities in settings appropriate to their needs in a more cost effective manner.

II. INVESTIGATION

On August 21, 2008, we notified then-Governor Tim Kaine of our intent to conduct an investigation of CVTC, pursuant to CRIPA, 42 U.S.C. § 1997. We conducted on-site tours of CVTC on November 18-21, 2008, December 17-18, 2008, and April 27-29, 2009, with the assistance of expert consultants in the fields of protection from harm, habilitation, and treatment programming.

On April 23, 2010, we notified the Commonwealth that we were expanding our investigation to focus on the State's compliance with the ADA and Olmstead with respect to individuals at CVTC. On August 17-20, 2010, we conducted a tour to examine whether the State is serving individuals confined to CVTC, and those discharged from CVTC, in the most integrated setting appropriate to their needs. We were assisted by consultants with expertise in discharge planning and serving individuals with intellectual and developmental disabilities in the community.

During the course of the expanded investigation, however, it became clear that an examination of the Commonwealth's measures to address the rights of individuals at CVTC under the ADA and Olmstead implicated the statewide system and required a broader scope of

review. We received information regarding the Commonwealth's efforts both to discharge individuals to more integrated settings and to prevent unnecessary institutionalization. While much of our review focused on CVTC, many of the policies and practices we examined are statewide in their scope and application. For example, the same community-based services are necessary to facilitate discharge of individuals from the other training centers, and individuals are discharged from CVTC to regions throughout the State.

While on site, we interviewed persons in statewide leadership positions in the Department of Behavioral Health and Developmental Services ("DBHDS"); CVTC administrators, professionals, staff, and residents; community providers; Community Service Board directors; and individuals receiving services in more integrated settings in the community. We observed individuals receiving services in a variety of settings, including in their residences and day activity areas. Before, during, and after our visits, we reviewed policies, procedures, individual records, and other material related to the care and treatment of individuals at CVTC. At the end of each of our inspections, consistent with our pledge of transparency and to provide technical assistance where appropriate, we provided an exit presentation at which our consultants conveyed their initial impressions and concerns about CVTC – and Virginia's system for providing services to individuals with intellectual and developmental disabilities – to the Commonwealth's counsel, CVTC administrators and staff, and other Commonwealth officials.

III. BACKGROUND

CVTC is a State-operated institution in Madison Heights, Virginia, operating as an intermediate care facility for persons with developmental disabilities (ICF/DD). CVTC is the largest of Virginia's five State-operated institutions, with approximately 400 individuals there. A total of approximately 1,100 individuals are in these five ICF/DDs. CVTC and the other training centers are operated by DBHDS. Approximately 8,600 individuals receive services through two different types of Medicaid "waivers"[1] in the community, and another 6,400 are on a waitlist. Services are coordinated through the 40 locally-run community service boards ("CSBs") that provide direct services and link consumers to services provided by other direct providers.

The average cost of institutionalizing a person at CVTC and other training centers is approximately $194,000 per year. By contrast, the cost of services to people in the community through the use of a waiver averages $76,400. Virginia can serve nearly three people in the community for each person in a training center.

Commonwealth officials are aware of the deficiencies that we identified during our investigation and have acknowledged the need for significant improvements. We are encouraged that Virginia leadership, both at CVTC and at DBHDS, acknowledged the problems and indicated a strong desire to work with the United States Department of Justice toward an amicable resolution. We are further encouraged by your recent statements and by positive measures in your budget proposal that support a transition to a community-based system for

[1] Section 1915(c) of the Social Security Act permits the waiver of certain Medicaid statutory requirements to enable states to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization.

serving individuals with intellectual and developmental disabilities as an alternative to institutionalization.

IV. FINDINGS

We conclude that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs as required by the ADA. The quantity of available services in the community is deficient, preventing individuals from being discharged from CVTC and other institutions and placing others at risk of unnecessary and expensive institutionalization. Discharge and transition planning is plagued with deficiencies, resulting in very few discharges from CVTC and the other training centers in the last several years. These inadequacies have resulted in needless and prolonged institutionalization of individuals with disabilities who could be served in the community with more independence and dignity at a fraction of the cost. While needlessly institutionalized, these individuals suffer harms and are exposed to the risk of additional harm.

Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2). For these reasons, Congress prohibited discrimination against individuals with disabilities by public entities:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. "The ADA is intended to insure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides, and ignores them." Helen L. v. DiDario, 46 F.3d 325, 335 (3rd Cir. 1995).

One form of discrimination prohibited by Title II of the ADA is violation of the "integration mandate." The integration mandate arises out of Congress's explicit findings in the ADA, the regulations of the Attorney General implementing Title II,[2] and the Supreme Court's decision in Olmstead, 527 U.S. at 586. In Olmstead, the Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. Id. at 607.

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[2] The regulations provide that "a public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d); see also 28 C.F.R. § 41.51(d). The preamble discussion of the ADA "integration regulation" explains that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A. at 571 (2009).

In so holding, the Court explained that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Id. It also recognized the harm caused by unnecessary institutionalization: "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." Id. at 601.[3] The Fourth Circuit has also clearly stated that federal law requires "plac[ing] the recipient in the least restrictive environment." Doe v. Kidd, 501 F.3d 348, 358 (4th Cir. 2007) (citing Olmstead, 527 U.S. 581), cert. denied, 522 U.S. 1243 (2008).

The Commonwealth is failing to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs, in violation of its obligations under the ADA and Olmstead. Individuals are unnecessarily institutionalized at CVTC and the other training centers, and individuals in the community are placed at risk of unnecessary institutionalization. The principal causes of Virginia's departure from the ADA's integration mandate are a lack of services in the community, particularly for individuals with complex needs, and a slow and muddled discharge and transition planning process.

A. Individuals with Intellectual and Developmental Disabilities Are Unnecessarily Institutionalized at CVTC and Other Training Centers

The Commonwealth is violating the ADA by unnecessarily institutionalizing hundreds of individuals at CVTC and other training centers who could be served in more integrated settings. Olmstead, 527 U.S. at 607.

1. CVTC and the Other Training Centers are Segregated, Institutional Settings that Expose Individuals to Harm

CVTC is a segregated, institutional setting. Approximately 400 individuals with intellectual disabilities are congregated together at CVTC. Individuals are assigned to units of eight to 12 people. Bathroom areas are congregate, with towels and other items often stored in separate areas not readily available to residents. As a result, individuals have very limited privacy. CVTC has the physical appearance of an institution, not a home. Day rooms are bare and impersonal, with minimal decorations and little home-like furniture. Accord Disability Advocates Inc. (DAI) v. Paterson, 653 F. Supp. 2d 184, 200-07 (E.D.N.Y. 2009) (describing characteristics of institutions to include, *inter alia*, large numbers of individuals with disabilities congregated together, an institutional appearance, and lack of privacy).

Individuals at CVTC live segregated lives. Most spend their entire day in the institution, with the vast majority participating in facility-based day activities. Individuals are offered very

[3] Olmstead therefore makes clear that the aim of the integration mandate is to eliminate unnecessary institutionalization and enable individuals with disabilities to participate in all aspects of community life. Accord Press Release, The White House, "President Obama Commemorates Anniversary of Olmstead and Announces New Initiatives to Assist Americans with Disabilities" (June 22, 2009) (In announcing the Year of Community Living Initiative, President Obama affirmed "one of the most fundamental rights of Americans with disabilities: Having the choice to live independently.").

limited opportunities for meaningful employment and have virtually no opportunities to interact with their non-disabled peers. CVTC limits individuals' autonomy and provides few opportunities for individuals to make choices. Individuals eat together in dining areas at set mealtimes, where they cannot choose what or when they eat. Staff determine what programs individuals watch on the television set in the day room. Id. (institutional characteristics include, *inter alia*, regimented daily activities, little autonomy and opportunity for choices, and limited opportunities to interact with individuals outside the institution); Benjamin v. Dep't of Pub. Welfare of the Commonwealth of Pa., Memorandum and Order, Case No. 09-1182 (Docket Entry 88) (M.D. Pa. Jan. 27, 2011) (finding that the Commonwealth of Pennsylvania unnecessarily institutionalizes individuals in large ICF/DDs in violation of the ADA and holding that such placements are segregated, where individuals are congregated together in living units, primarily receive day services on the grounds of the facilities, and have limited opportunities to interact with non-disabled peers and limited access to community activities). The Commonwealth has acknowledged, in interviews with officials and in reports, that nearly all individuals at the training centers could and should be served in smaller community-based settings.

Individuals are harmed at CVTC. Unnecessary segregation not only violates individuals' rights under the ADA, but also causes irreparable harm. "[O]ne of the harms of long-term institutionalization is that it instills 'learned helplessness,' making it difficult for some who have been institutionalized to move to more independent settings." DAI, 653 F. Supp. 2d at 265; accord Marlo M. v. Cansler, 679 F. Supp. 2d 638 (E.D.N.C. 2010) (finding unnecessary institutionalization leads to regressive consequences that cause irreparable harm); Long v. Benson, 2010 WL 2500349 (11th Cir. June 22, 2010) (affirming district court's granting of preliminary injunction based on irreparable injury of unnecessary institutionalization).

Moreover, CVTC compounds this harm by exposing individuals to unsafe conditions while they are needlessly institutionalized. See Youngberg v. Romeo, 457 U.S. 307, 324 (1982) (finding that the Fourteenth Amendment's due process clause requires an institution to provide "adequate food, shelter, clothing, and medical care," along with "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests"). Individuals at CVTC are subjected to significant harms, including repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports. An overarching cause of these harms is CVTC's failure to identify individuals' needs, identify root causes of bad outcomes, and respond to prevent their recurrence. These harms not only evidence the need for CVTC to put in place adequate quality assurance mechanisms, but underscore the urgency of moving individuals with disabilities out of inappropriate institutional placements.

Particularly concerning during our initial tours in 2008-09 was CVTC's use of restraints. The right to be free from undue bodily restraint is the core of the liberty interest protected from arbitrary governmental action by the Due Process Clause. Id. at 316. Restraints may only be applied in emergency situations necessary to prevent harm and for only the length of time necessary for the emergency to subside. 42 U.S.C. § 290ii(b) (federal rules regulating the use of restraints on individuals in ICF/DDs). Yet, at CVTC, restraints were not limited to emergency situations. Instead, planned restraints were part of many individuals' treatment plans, where they were used as an intervention of first, rather than last, resort. We also found evidence that several

individuals resisted efforts of staff to get them to use what CVTC termed "voluntary" restraints, raising questions about whether these restraints are voluntary at all.

2. Individuals at CVTC and the Other Training Centers Could be Served in More Integrated Settings

Individuals at CVTC and the other training centers could be served in more integrated settings. The Commonwealth has acknowledged this both explicitly and implicitly through its efforts, albeit incomplete, to serve individuals in the community who have needs similar to those of individuals at CVTC and the other training centers. We conclude that the vast majority of individuals could be – and have a right to be – living in community settings with appropriate services and supports but are instead languishing in the institution.

Virginia already has a range of community-based services for individuals with intellectual and developmental disabilities. These community services cost substantially less than institutional care. See supra. Virginia has developed a Medicaid-funded waiver program, known as the ID Waiver, to provide home and community-based services to individuals with intellectual disabilities who meet the level of care for ICF/DDs (which include the training centers) and are in or at imminent risk of entering such facilities. Waiver services include assistive technology; companion services; crisis stabilization and crisis supervision; day support; environmental modifications; in-home residential support services; residential support services; respite services; personal assistance; personal emergency response system; prevocational services; skilled nursing; supported employment;[4] therapeutic consultation; and transition services.[5]

Residential options under the waiver include small group homes, sponsored homes where a licensed provider contracts with a family to provide services for up to two individuals, in-home residential support programs to serve individuals in their own homes or their families' homes, and adult foster care programs that are similar to sponsored homes and provide room and board, supervision, and services in the provider's home for up to three adults.[6] We found that, among

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[4] While we recognize that the State provides integrated supported employment opportunities, our tours raised serious initial concerns about the over-reliance on segregated, sheltered workshops for individuals with intellectual and developmental disabilities in the community. Many of the day programs we visited also did not provide individuals with opportunities for meaningful work. These deficiencies place individuals at risk of continued segregation even once they are discharged.

[5] Virginia has a separate waiver for individuals who have a developmental disability (such as autism), but not an intellectual disability, called the Individual and Family Developmental Disabilities Support Waiver (DD Waiver). Like the ID waiver, the DD waiver contains a range of support services including in-home residential support, day support, skilled nursing, crisis services, respite, personal attendant care, and supported employment.

[6] Virginia also offers congregate, more institutional-like settings in the community, including ICF/DDs that serve between five and 12 individuals and assisted living facilities that provide or coordinate personal and health care services with 24 hours per day of supervision in a

the placements we visited, individuals were generally kept safe and provided appropriate supports and services.[7]

The Commonwealth has acknowledged that most people at the training centers, including nearly every individual at CVTC, could be served in the community. In its recent study, Creating Opportunities: Plan for Advancing Community-Focused Services in Virginia (June 25, 2010), the Commonwealth noted, "Individuals in training centers could be served in the community if adequate supports, including targeted medical and behavioral interventions, were available to them." Similarly, the Director of Developmental Services, Lee Price, told us during our August 2010 visit that he believed that everyone at CVTC could be served in the community. CVTC staff has already determined that more than 170 individuals at CVTC could be served in more integrated settings, and the number is undoubtedly far higher due to CVTC's inadequate discharge assessment process.

The needs of individuals at CVTC – including individuals with complex medical or behavioral needs – are the same as the needs of other individuals who are currently served in the community in Virginia and in other states, including in states that have no institutional settings. Community providers confirmed that the vast majority of individuals from CVTC could be served in the community with appropriate supports and services. They also stated that they currently serve individuals who have similar needs to people at CVTC, including individuals with complex medical or behavioral needs. While the pace of discharge to the community of individuals from CVTC and the other training centers has been unacceptably slow, see infra, the individuals who have transitioned have similar needs to those individuals who remain at CVTC.[8] Thus, providers and the Commonwealth have already demonstrated an ability and a willingness

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larger group setting. These placements are not funded using waivers. For many individuals, these are not the most integrated settings appropriate to their needs.

[7] Recently, most individuals have been discharged into sponsored homes or small group homes, with only a small number of individuals moving to larger ICF/DD facilities. While our sample size was too small to make any firm conclusions, we were encouraged by the overall quality of the community placements we visited. However, we had concerns regarding two of the residential placements, including one larger congregate setting. In that case, the Commonwealth had investigated reports of abuse, the primary responsible staff member was terminated, but the Commonwealth did not provide adequate follow-up to ensure that appropriate corrective action was taken with respect to other staff who may have been present during or known about the abuse. Just as it must do at the training centers, the Commonwealth must ensure that its investigation, monitoring, and licensing procedures adequately address any potential harms at community-based placements. See infra.

[8] The Commonwealth's own reports have indicated, and other information confirms, that individuals at other institutions have similar needs and could be served in the community and that individuals with needs similar to individuals at other training centers are likewise receiving services in the community. See Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010; Information Brief: Virginia SIS Comparisons for SEVTC and Comprehensive Community Waiver Populations, Human Services Research Institute (on behalf of DBHDS), June 23, 2009.

to serve people with complex needs in community settings. Accord Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 6 ("With appropriate community services, all of the named Plaintiffs [with developmental disabilities] could live in more integrated community settings rather than institutions because they would still have available all services and supports that are currently available to them.").

During our tours, we met former CVTC residents living and otherwise participating in more integrated settings. The needs of these former CVTC residents are no different than those of the individuals currently at CVTC. Many of them have complex medical and/or behavioral needs but nonetheless are successfully living in community-based settings, where they live with more independence, dignity, and self-determination. We observed that these individuals were living in home-like environments; were able to make choices like how to spend their day, what to eat, and how to decorate their rooms; had access to community-based services and activities; and were safe from harm. Former CVTC residents whom we met included:

- AA, whom we met in a sponsored home and who owns his own bowling shoes and bowling ball, has a membership at the local "Y," has lunch at a senior center twice a week, frequently visits a friend in a nursing home, and goes to a recreation center each week.[9]
- BB, a deaf woman whom we met in a sponsored home who goes into the community nearly every day. Her sponsored family includes her in family life through their use of modified sign language.
- CC, who engages in community activities, including church several days a week.
- DD, whom we met at a day program, who volunteers at a local fire department.
- EE, who enjoys bowling despite having cataracts and hearing impairment.

3. Few Individuals Are Discharged from CVTC or the other Training Centers to More Integrated Settings

Virginia relies heavily on institutional care for individuals with intellectual and developmental disabilities. Despite the Commonwealth's recognition that individuals at CVTC and the other training centers could be served in more integrated settings, Virginia citizens with intellectual and developmental disabilities remain institutionalized, and very few individuals are actually transitioned into the community. This use of institutional care has significant financial costs for the Commonwealth.

The Commonwealth continues to spend far more proportionally on institutional than community care, in large part due to the substantially higher average cost of serving individuals in institutions than in the community. It continues to invest millions of dollars in new construction and remodeling of its training centers instead of seriously investing in the

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[9] To protect individuals' privacy, we identify them by initials other than their own. We will separately transmit to the Commonwealth a schedule that cross-references the initials with individuals' full names.

community services necessary to transition people. The Commonwealth's long-range plan for CVTC is that it maintain a census of 300. As noted earlier, however, CVTC staff already have determined that 170 of the 400 current residents are ready for discharge. Virginia is one of only five states that continue to operate multiple large (16+ beds) state-run institutions for individuals with intellectual and developmental disabilities and of only a handful of states that has yet to close a single state-operated facility.

Individuals who could be served in more integrated settings languish at CVTC. Between July 1, 2008, and July 1, 2010, there was a net reduction in the CVTC population of only 10 individuals, a reduction rate of approximately five people annually. There were only 31 discharges in that two year period,[10] despite CVTC itself designating another 170 individuals as being capable of being served in more integrated settings. This unreasonably slow rate of discharge has remained fairly steady since 2004. Between July 1, 2008, and July 1, 2010, there were nearly as many admissions (21 individuals) as discharges, caused in large part by the Commonwealth's failure to develop sufficient community services to prevent unnecessary institutionalization. Out of the 31 people discharged since July 2008, half of those individuals were people who had been admitted during that same time period. Thus, virtually no one who has been institutionalized long-term in CVTC ever leaves.

Moreover, the large majority of individuals who have been designated as ready for discharge have been waiting for placement for a significant amount of time. Approximately 140 of the 170 so designated were placed on the list in 2007 or earlier. Some individuals have been "ready for discharge" for a decade or more. At the current rate of discharge, the vast majority of individuals at CVTC will not move into the community during their life time. Even those who will ultimately have the chance to move must first endure many more years of unnecessary institutionalization. The other training centers have seen similarly slow discharge rates. Under any standard, this does not constitute discharging at a reasonable pace.

B. A Lack of Services and a Flawed Discharge and Transition Planning Process Cause Unnecessary Institutionalization at CVTC and the Other Training Centers

Our experts identified two primary reasons why so few individuals are discharged from CVTC, and the other training centers, into the community. First, the Commonwealth has failed to develop sufficient community-based services, particularly for individuals with complex needs. Second, the Commonwealth's process for assessing and transitioning individuals into the community is flawed, creating unreasonable barriers to discharge.

1. The Commonwealth's Failure to Develop Sufficient Community Services is a Barrier to the Discharge of Individuals at CVTC and the Other Training Centers Who Could Be Served in More Integrated Settings

The lack of sufficient services in the community constitutes one of the primary barriers to discharging individuals from CVTC and other training centers. The Commonwealth already provides the types of services that individuals at CVTC would need to live successfully in the community. See supra. However, existing community services are inadequate and not available in sufficient supply. The Commonwealth should expand existing community programs that

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[10] At least one of these discharges was made to another training center.

already provide effective services and reject dated models that do not provide opportunities for full integration and self-determination. Community provider agencies have both the capacity and the willingness to develop additional services for individuals at CVTC.

First, the Commonwealth needs additional waiver slots to serve individuals who can be discharged from CVTC and other training centers. The Commonwealth has acknowledged the need for additional waiver slots. See Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010. But few slots are available, and none are specifically designated for individuals leaving the training centers. When a waiver slot becomes available, one of the now 3,000 individuals on the "urgent" wait list – who generally are individuals in the community experiencing crises that put them at risk of entering an institutional setting[11] – generally receives it, while individuals at CVTC or other training centers have lower priority. We understand that the Commonwealth makes waiver slots more readily available to those already in the community because it wishes to prevent further admissions. But the Commonwealth may not neglect the institutionalized population. Benjamin, Memorandum and Order, Case No. 09-1182 (Docket Entry 88), at 21 (holding that the State "cannot continue to [prevent admissions] by relegating institutionalized individuals to second-class status" and that the State's aim cannot "be achieved by discriminating against individuals who have equal rights to community support"). A sufficient number of additional slots, beyond the 275 in the current budget proposal and even beyond the 400 that the Commonwealth has said are the minimum required to address the waitlist, should be allocated to ensure that the institutionalized population is discharged at a reasonable pace.

The Commonwealth continues to direct resources to institutions at the expense of community-based programs, particularly as it underfunds its community-based waiver program. On average, it spends almost $120,000 more per year to serve a person confined to CVTC than in the community using a waiver. Virginia could serve nearly three people in the community for each person in a training center. Even individuals with significant medical needs can be served in the community at approximately half the cost of a training center ($92,000). The provision of community-based services to an individual with the most complex medical and/or behavioral needs, including services 24 hours a day, seven days a week, still costs $64,000 less per year than confining the same individual to a training center.

At the same time that the Commonwealth fails to allocate more resources to community-based services, it has failed to use a large number of slots made available through the Money Follows the Person ("MFP") program, which is specifically aimed at facilitating discharge from large institutions like CVTC and benefits from a higher rate of federal matching funds. Based on our experts' record reviews, there are individuals currently at CVTC who could have been transitioned to the community using MFP program funds. However, while using MFP slots would be a start, more is required.

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[11] The primary reasons for being placed on the "urgent" waitlist include an aging caregiver, a primary caregiver who can no longer care for the person, risk of abuse or neglect of the individual, or that the individual's behavioral or physical care needs are putting persons at risk.

Finally, the design of the waiver program has made it difficult to develop sufficient services for individuals with complex needs. This is particularly important for individuals in CVTC and other training centers, many of whom have complex medical and/or behavioral needs and will need significant levels of supports in the community. The Commonwealth itself has acknowledged that "[t]he current ID Waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals with needs for high intensity services," Creating Opportunities:Plan for Advancing Community-Focused Services in Virginia, at 25 (June 25, 2010), and that a more flexible waiver is necessary in order to serve individuals with complex needs, Northern Virginia Training Center Diversion Pilot, DBHDS, Nov. 1, 2010.[12]

Providers with whom we spoke confirmed this finding. Some providers indicated that the only way to develop adequate services for many people with complex physical, medical, or behavioral needs is for a CSB or private provider agency to create an ICF/DD facility, where funding is provided through an inclusive annual cost adjusted rate instead of through a waiver. This encourages the development of ICF/DD models that tend to be larger than other residential settings, have less community integration, are less homelike (e.g., large "exit" signs, crash bars on doors, and sometimes even nursing stations or staff offices), and provide less flexible programming. These homes are frequently more expensive than smaller, more integrated community residences or sponsored homes. Indeed, the Commonwealth's own practices appear to prefer the smaller group or sponsored homes, as only a small number of recent CVTC discharges have been made to ICF/DD facilities. Still, this structural problem in the Commonwealth's services improperly impedes individuals with more complex needs from living in community settings.

2. CVTC's Inadequate Discharge Planning and Transition Process is a Barrier to the Discharge of Individuals at CVTC Who Could Be Served in More Integrated Settings

CVTC's inadequate discharge planning and transition process is another significant barrier to serving individuals at CVTC in the most integrated setting appropriate to their needs. The discharge planning process fails to identify individuals who could be served in more integrated settings and creates unreasonable barriers to discharge that lead to an unacceptably slow discharge process. The process also fails to ensure that adequate information is provided to families about community-based options and fails to address families' questions or concerns.

a. The Commonwealth's Treatment and Discharge Planning Process Does not Meaningfully Identify People's Needs, Barriers to Discharge, and Ways to Address Those Barriers

The purpose of the discharge planning process is to identify individuals' needs, identify what services are necessary to meet those needs in a more integrated setting, and identify barriers

[12] Some aspects of the rate system that impede appropriate service development for this complex population include: very short time limits for crisis stabilization services, barriers to funding 24 hour nursing services or supervision, and difficulty obtaining environmental modifications, assistive technology, and adaptive equipment.

to discharge and strategies to address them. See Kidd, 501 F.3d at 358 (holding that the State "must determine the services required because it must insure that it meets the needs of the recipient and that it places the recipient in the least restrictive environment, as required by state and federal law") (citing Olmstead, 527 U.S. 581). Discharge planning should start from the presumption that every individual is capable of being served in a more integrated setting. Planning for discharge must begin from the moment of admission and drive treatment planning. Discharge planning and treatment are inextricably tied; the purpose of treatment must be to address the underlying issues that led to the admission and to resolve barriers to discharge to a more integrated setting. We found that significant inadequacies in CVTC's treatment and discharge planning processes are creating unnecessary barriers to discharging individuals at CVTC who could be served in more integrated settings.

First, we found that treatment plans frequently reflect an outdated view of disability, emphasizing individuals' deficits rather than identifying needed supports. A team cannot make a determination of the most integrated setting appropriate for an individual unless they meaningfully understand the individual's needs and the supports necessary to meet them. We also found that many treatment plans do not reflect individualized planning and are not integrated across disciplines. They do not describe the individual's goals or personal preferences, including goals and desires regarding living in a more integrated setting.[13] When goals are listed, they typically are framed as generic treatment goals. Likewise, the discharge planning process inappropriately focuses on the individual's "readiness" rather than on identifying the community services necessary to meet the individual's needs.

The monthly review meetings we attended did not include substantive discussion of discharge planning or barriers to placement, and monthly review summaries similarly failed to address these issues. Additionally, we found that the individuals and their families or guardians were not consistently present at monthly review meetings.[14] At least two individuals – FF and GG – did not attend their monthly review meetings during our visit. Further, when individuals were present at meetings that we attended, no effort was made to engage them actively in their treatment.

Many of the treatment plans that our expert reviewed failed to provide adequate opportunities to engage in activities aimed at facilitating independence and preventing the regression of skills while the individual is institutionalized.[15] We observed individuals who did

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[13] In addition, on our tours in 2008-09, we found that CVTC failed to provide individuals with appropriate communication services, hindering their ability to express personal goals and preferences and to participate meaningfully in their treatment and discharge, and also creating barriers to community integration. That review revealed that many individuals with significant communication impairments did not have formal communication goals and programs and that CVTC's speech and language professional resources were inadequate. This deficiency also has implications for individuals' ability to participate in the discharge planning process and to provide input regarding preferred placements in the community.

[14] We use the term "guardian" loosely to apply to the legal guardian or to the "Legally Authorized Representative."

[15] Federal regulations require that:

not appear to be meaningfully engaged in active treatment, and reviewed individual schedules that included minimal meaningful activities, at best. During our visit, CVTC staff reported that the facility has an expectation that all individuals will participate in four hours of day programming and in two hours of recreation or community activities each day. Our review revealed that this minimum expectation was not met for a significant number of individuals. We also found that only a small number of individuals were actually engaged in meaningful work. For instance, at the time of our visit staff reported that only a total of 42 individuals received pay for work and that there was no wait list for participating in work opportunities. This suggests that CVTC is not actively promoting work opportunities or seeking to ensure that individuals are offered such opportunities.

Further, we found that CVTC's process for determining the appropriateness of community placement, as set forth in written policy and described by staff, is inconsistently applied.[16] As a result, individuals who, according to CVTC's own criteria, are ready for discharge, remain unnecessarily institutionalized. Our expert reviewed cases in which individuals had identical scores on the "Protocol for Placement of Clients on the Ready for Discharge List," yet some were placed on the discharge ready list while others were not. In addition, the decision about placement reached on the "Training Center/Community Service Board Needs Upon Discharge Form" was inconsistent with the score on the Protocol. There was no evidence that Quality Assurance activities were in place to ensure consistency. The following examples are illustrative of the ambiguity inherent in determining which individuals are appropriate for discharge:

- HH was admitted to CVTC on April 16, 1956, at age 15. She has met the Discharge Ready Criteria since November 19, 2009; however, for reasons that are unclear, she was not placed on the Discharge Ready List.
- II was admitted on February 19, 1985, at age 36. A progress note on January 27, 2010, indicates that the team would agree that, with necessary supports, II would be able to function in a community setting. Two days later, on a separate form, II did not meet the discharge readiness criteria.

> Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services . . . that is directed toward – [t]he acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and . . . [t]he prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a).

[16] The practices that are in place at this facility are the same Policies and Procedures that are used at all of the Virginia training centers. The issues and barriers that were found at CVTC are likely to exist at the other training centers, as well.

- JJ was admitted to CVTC on August 13, 1962, at age 8. On March 16, 2010, she was listed as meeting the Discharge Ready Criteria, and the guardian agreed to consider community placement; however, she was not placed on the Discharge Ready list.

While clarifying the process is advisable, the fundamental point is that the overwhelming majority of individuals at CVTC can be served in the community, including those who have not been formally identified as eligible for discharge. See DAI, 653 F. Supp. 2d at 258-59 (holding that Olmstead does not "create a requirement that a plaintiff alleging discrimination under the ADA must present evidence that he or she has been assessed by a 'treatment provider' and found eligible to be served in a more integrated setting"); Joseph S. v. Hogan, 561 F. Supp. 2d 280, 291 (E.D.N.Y. 2008) (noting that "the language from Olmstead concerning determinations by 'the State's treatment professionals' appears to be based on the particular facts of the case and not central to the Court's holding") (internal citation omitted); Frederick L., 157 F. Supp. 2d at 541 ("[The court]do[es] not read Olmstead to require a formal 'recommendation' for community placement."). Indeed, "Olmstead does not allow States to avoid the integration mandate by failing to require professionals to make recommendations regarding the service needs of institutionalized individuals with mental disabilities." Id. at 540. See also DAI, 653 F. Supp. 2d at 259; Long v. Benson, No. 08-cv-26 (RH/WCS), 2008 WL 4571905, at *2 (N.D. Fla. Oct. 14, 2008) (noting that the State "cannot deny the right [to an integrated setting] simply by refusing to acknowledge that the individual could receive appropriate care in the community").

b. CVTC Staff are Not Adequately Knowledgeable of Available Community Services and Do Not Sufficiently Coordinate with Providers

CVTC staff lack knowledge of community services and fail to coordinate with community providers. As a result, CVTC staff do not have the information they need to be able to make recommendations about how an individual's needs could be met in a more integrated setting, to present families with specific proposals for community residences and services, or to answer families' questions about community living. Cf. 28 C.F.R. pt. 35, App. A, p.450 (1998) (requiring an individual to have an "option of declining to accept a *particular* accommodation") (emphasis added). CVTC staff often fail to explain even the types of services available in the community or the benefits of community living, though such a discussion "could make a substantial difference in the number of referrals for placement." Messier v. Southbury Training Sch., 562 F. Supp. 2d 294, 338 (D. Conn. 2008).

The lack of coordination between CVTC staff and community providers contributes to the long delays in the transition from CVTC to the community. Providers do not have sufficient information about the needs of people at CVTC to develop services for them. Moreover, CVTC staff fail to utilize community providers as resources to educate individuals and their families about community living, such as having providers speak with them, coordinating visits for individuals considering community placement and their families, and facilitating conversations with individuals currently living in the community and their families. Providers want to be more involved in the service development and transition planning process and are more effective when they are.

We identified individuals for whom discharge took many months, even after a provider and a residence were selected. Several people are still at CVTC despite a provider and residence being selected more than two years ago, and despite guardian approval. The following examples illustrate a pattern of CVTC failing to make meaningful efforts to coordinate discharge, even where the individual has been identified as discharge-eligible and the guardian is in agreement:

- KK was admitted to CVTC on August 30, 1962, at age five. KK met the Discharge Readiness Criteria in May 2006 after the guardian agreed to support placement in April 2006. KK was placed on the Discharge Ready List on June 30, 2006. After three years of being "discharge ready" but not discharged, in May 2009, the guardian changed her mind about community placement. There was no evidence that the team addressed the guardian's concerns regarding how KK's health needs would be met in the community.

- LL was admitted to CVTC on October 12, 1959, at age six. He was listed as ready for discharge on June 12, 2007, and also had guardian approval. He was placed on the Discharge Ready List on November 2, 2007. LL's residential placement has been delayed four times. As of May 2010, he continued to meet the criteria in the placement protocol, including the fact that he can participate in discharge planning. There are no funds available for needed adaptive equipment, so the CSB Case Manager is looking for grants to fund this item. There was no indication that the team considered the Money Follows the Person program that provides funds for start-up services.

- MM was admitted to CVTC on March 1, 1972, at age 12. She was placed on the Discharge Ready List in April 2006 with an indication that the family was in support of discharge. The State form indicated that in March 2008 "nothing is available at this time." A State form on June 9, 2009, indicates "Nothing available at this time." The record does not demonstrate any efforts to make something available.

C. Individuals with Intellectual and Developmental Disabilities Currently Being Served in the Community Are At Risk of Unnecessary Institutionalization

The ADA's integration mandate applies both to people who are currently institutionalized and to people who are at risk of unnecessary institutionalization. See Radaszewski v. Maram, 383 F.3d 599 (7th Cir. 2004) (ADA applied to individual at risk of entering a nursing home); Fisher v. Okla. Health Care Auth., 335 F.3d 1175 (10th Cir. 2003) (same); Helen L., 46 F.3d at 325 (holding that the ADA was offended where a person with disabilities was offered personal care services in an institutional setting but not at home). We found that individuals in the community are at risk of unnecessary and costly institutionalization because of the Commonwealth's failure to provide sufficient community-based services. As Virginia discharges individuals from the training centers, as discussed above, it must redirect expenditures from costly institutional care to address these deficiencies in community services.

More than 6,000 individuals are on a waitlist for services in the community. Nearly 3,000 of those individuals are on the "urgent" list, meaning that they are in situations that place them at significant risk of institutionalization. See fn 11. Some of these individuals have been, and will continue to be, forced into institutions when a crisis arises while they wait for community services. As evidence of this, CVTC has had nearly as many admissions as it has had discharges over the last several years. See supra.

An inadequate number of waiver slots and the inflexibility of the waiver, particularly for individuals with complex needs, place individuals in the community at risk of unnecessary institutionalization. The Commonwealth admits that "[w]ithout significant changes to [the] waiver program's services, payments rates, and structure, little more can be done to divert admissions to training centers for the most medically fragile and behaviorally challenging individuals." Northern Virginia Training Center Diversion Pilot, DBHDS, at 11, Nov. 1, 2010; id. at 10 ("The ability of CSBs to divert an admission to [a] training center can be limited because of insufficient resources to purchase care in the community."). The Commonwealth must expand slots to address the needs of individuals who face the real threat of unnecessary institutionalization. The Commonwealth's own reports recommend between 400[17] and 1,000 new slots each year over the next several years to address the waitlist alone. Id. at 9; The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers, at 4, 18 (2005). The current proposal of 275 waiver slots, while commendable, is far from adequate.

The Commonwealth's lack of capacity places individuals at risk of unnecessary institutionalization. The number of short term admissions for crisis services underscores the gap in Virginia's system.

We found that a primary cause of admissions to CVTC is the lack of crisis services for individuals with acute medical or behavioral issues. The Commonwealth recognizes that "additional crisis intervention and crisis response resources are needed to divert behavioral crisis admissions to training centers," Northern Virginia Training Center Diversion Pilot, DBHDS, at 6, Nov. 1, 2010, and that "[t]here is a documented need for additional crisis intervention and crisis stabilization services," including to prevent admissions to the training centers or other forms of institutionalization, id. at 8. Respite services are also essential to diverting unnecessary admissions. A shortage of available respite services "may create situations where individuals have no choice but to be admitted" to a training center for respite care. Id. at 10. The Commonwealth's current budget proposal to significantly cut respite care will make it more difficult for families to keep their loved ones at home and in the community.[18]

...

In summary, the Commonwealth violates the ADA by unnecessarily institutionalizing individuals at CVTC and other training centers who could be served in the community and by placing individuals currently in the community at risk of unnecessary institutionalization.

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[17] An increase of 400 slots per year averages to just ten slots per CSB, or less than one per month per CSB.

[18] Supported employment and other integrated day activities can also help prevent unnecessary institutionalization by helping individuals build a natural support system and by minimizing boredom and feelings of isolation that can contribute to behaviors that require crisis responses. Moreover, meaningful day activities, including supported employment, help individuals pursue their preferences and goals and feel challenged and stimulated. As discussed above, the State appears to be overly reliant on segregated sheltered workshops and day programs that offer little opportunity for real community integration, even though the State also offers more integrated supported employment opportunities.

Individuals suffer harm and are placed at risk of harm while needlessly institutionalized. The Commonwealth has failed to ensure an adequate supply of community-based services, particularly for individuals with complex needs, necessary for the discharge of individuals from the training centers and for the prevention of unnecessary admissions of individuals waiting for services in the community. Moreover, the rate of discharge of individuals from CVTC and other training centers into the community is far too slow, caused in significant part by a flawed discharge planning process and the lack of sufficient community-based alternatives. The Commonwealth's violations of the ADA come at a huge financial cost to all of its citizens.

V. RECOMMENDED REMEDIAL MEASURES

To remedy the deficiencies discussed above and protect the constitutional and federal statutory rights of both individuals in CVTC and, where appropriate, other training centers, and those at risk of being institutionalized at CVTC and other training centers, the Commonwealth should promptly implement the minimum remedial measures set forth below:

A. Serving Individuals with Intellectual and Developmental Disabilities in the Community

The Commonwealth must increase community capacity by allotting additional waivers and expanding community services to serve individuals in or at risk of entering the training centers. A sufficient number of waivers – far more than what the Commonwealth has currently budgeted – must be available to address both individuals confined to the training centers and those on the waitlist in the community. The Commonwealth should also take full advantage of opportunities available to it, including the Money Follows the Person program, to develop services for individuals being discharged from CVTC and the other training centers. As the State downsizes its institutional population, the State should realign its investment in services for individuals with intellectual and developmental disabilities away from institutions to prioritize community-based services.

As a means of preventing institutionalization, the Commonwealth should develop crisis services, preserve the respite services it has been providing, and provide integrated day services, including supported employment. The Commonwealth should move away from its reliance on sheltered workshops.

Virginia should make modifications to its Medicaid waivers or explore the development of additional waivers to facilitate the development of integrated and individualized community services for people with complex physical, medical, and behavioral needs. New targeted waivers for specialty populations could also be developed.

The Commonwealth should ensure that its quality management systems are sufficient to reliably assess the adequacy and safety of treatment and services provided by community providers, the CSBs, and CVTC. The systems must be able to timely detect deficiencies, verify implementation of prompt corrective action, identify areas warranting programmatic improvement, and foster implementation of programmatic improvement.

B. Discharging Individuals from CVTC and the Other Training Centers

The Commonwealth must implement a clear plan to accelerate the pace of transitions to more integrated community-based settings. The Commonwealth must overcome what has become an institutional bias in its system.

Discharge planning must begin at the time of an individual's admission. The process should be improved and simplified and should focus on needed services. Rather than determining whether an individual is "ready" for discharge, the Commonwealth must focus on which services each individual will require in the community and should begin constructing a plan for providing such services and facilitating discharge. The default cannot be institutionalization. The discharge and transition plan should include the individual's preferences, a discussion of how the individual will access services, and a plan on how to coordinate care among multiple providers, if applicable.

Assessment teams must become knowledgeable about community living options and services. During the treatment planning process and in implementing individual treatment plans, the Commonwealth should ensure that barriers to discharge are identified and addressed and, for individuals with a history of re-admission, that factors that led to re-admission are also analyzed and addressed. Treatment planning should be individualized, person-centered, and multidisciplinary, and it should include the individual and his family.

In order to ensure an appropriate transition upon discharge, the Commonwealth should engage identified community providers in the discharge planning process as far in advance of discharge as possible and develop and implement a system to follow up with individuals after discharge to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission. The community-based service agencies must be made full partners in the process of planning, developing, and preparing services for individuals, much like the CSBs are currently. The Commonwealth cannot rely primarily on staff at the institution. The Commonwealth must develop a process to clearly identify existing vacancies and explicitly review the physical or programmatic adjustments needed in those vacancies to match this capacity with an individual's needs as part of individualized discharge planning and to facilitate long-range planning. The Commonwealth should emphasize placement into smaller community homes in its transition planning.

The Commonwealth should also create, revise, and implement a quality assurance or utilization review process to oversee the discharge process. The quality assurance process should include, at a minimum: developing a system to review the quality and effectiveness of discharge plans; developing a system to track discharged individuals to determine if they receive care in the community as prescribed at discharge; and identifying and assessing gaps in community services identified through the tracking of discharge outcomes.

If any individual or guardian opposes placement, the training center should document the steps taken to ensure that they are making an informed choice. The training centers should implement strategies to address individual concerns and objections to placement. Families should be provided the opportunity to visit potential placements and to speak with provider agency staff and with other families whose loved ones live in the community.

The Commonwealth should make all efforts to prevent new admissions to the training centers, including expanding community services necessary to divert individuals and stabilize them in the community. If an individual is referred to a training center, however, Virginia must ensure that, before an individual is admitted, the person receives a professionally-based assessment to ensure that admission is necessary and that the institution is the most integrated setting appropriate to serve the needs of that individual.

VI. CONCLUSION

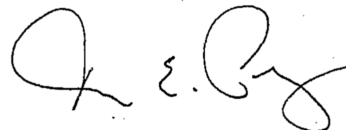
Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. Although we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the Commonwealth in an amicable and cooperative fashion to resolve our outstanding concerns with respect to the services the Commonwealth provides to persons with intellectual and developmental disabilities at CVTC and other settings across the Commonwealth. Assuming that our cooperative relationship continues, we are willing to send our consultants' written evaluations – which are not public documents – under separate cover. Although the consultants' reports do not necessarily reflect the official conclusions of the Department of Justice, the observations, analysis, and recommendations contained therein provide further elaboration of the issues discussed in this letter and offer practical technical assistance to help address them.

We hope that you will give this information careful consideration and that it will assist in facilitating a dialogue swiftly addressing the areas that require attention.

We are obligated to advise you that, in the unexpected event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to the ADA once we have determined that we cannot secure compliance voluntarily, 42 U.S.C. § 2000d-1, and pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them, 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with the Commonwealth and are confident that we will be able to do so. The Department of Justice attorney assigned to this investigation will be contacting the Commonwealth's attorneys to discuss this matter in further detail. If you have any questions regarding this letter, please call Jonathan Smith, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-5393.

Sincerely,



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Assistant Attorney General

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Appendix 2

COMMONWEALTH of VIRGINIA

Office of the Inspector General

G. Douglas Bevelacqua
Inspector General
for
Behavioral Health and
Developmental Services

May 11, 2011

The Honorable Donald M. Berwick, M.D., Administrator
Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
200 Independence Avenue, S. W.
Washington, D. C. 20201

Re: *Urgent request for clarification concerning the use of restraint to medicate over patient objection: 42 CFR Part 482*

Dear Dr. Berwick,

Pursuant to the *Code of Virginia*, § 37.2-425, the Office of the Inspector General (OIG) is statutorily obliged to investigate reports of abuse, neglect, or inadequate care occurring in its state operated facilities and other programs in the Commonwealth of Virginia operated by licensed providers and to recommend corrective action for consideration by the Governor and the General Assembly.

Recently, the OIG received a complaint from a legal guardian that her adult child, a patient in a state operated behavioral health facility with serious mental illness, was not receiving medically necessary treatment, prescribed by the attending psychiatrist, because the patient refused to agree to the injection and the hospital had been instructed by Virginia's Office of the Attorney General (OAG) that restraint could not be used to administer medication to a patient even though this patient had been determined by the court to lack the capacity to make informed medical decisions and a guardian subsequently appointed with the specific authority to make medical decisions on the patient's behalf.

The instant case led to a review by the OIG and our determination that the denial of medically necessary treatment may constitute abuse and neglect under the *Code of Virginia*. Therefore, we are petitioning you to resolve an ambiguity, or perhaps an unintended consequence, in 42 CFR Part 482 that has led the OAG to conclude that a person may only be restrained to administer medically necessary treatment if their *immediate physical safety* is jeopardized. The OIG believes that this regulation,

when read as a whole, supports providing palliative treatment to passive psychotic patients before their condition deteriorates further and their immediate physical safety is at risk, and that to deny palliative care may constitute abuse and neglect under Virginia law.

It is ironic that an interpretation of a Federal regulation whose stated purpose is to "ensure each patient's physical and emotional health and safety" disenfranchises scores of psychotic, but nonviolent, patients in Virginia's behavioral health facilities who are denied medically necessary interventions that would allow them to participate in their own lives. The controlling interpretation of this Federal regulation, advanced by the OAG, rules out the use of a brief restraint to administer medically necessary treatment that could restore a delusional person to a baseline of competency, except to ensure "the immediate physical safety of the patient, a staff member, or others."

In other words, regardless of an individual's capacity to make informed decisions about their medical care, a nonviolent psychotic patient can only be medicated if they agree to the injection, and a delusional person, lacking the capacity to make informed decisions, can only be restrained to be medicated once the *immediate physical safety* to self or others threshold has been crossed. A seriously mentally ill person, lacking capacity, who poses no immediate danger to his/her physical safety, cannot be medicated – unless they agree to the treatment.

On March 15, 2011, the OIG received a complaint from a court appointed guardian requesting that the OIG investigate the refusal of a state behavioral health facility to employ a medical hold (a restraint) to inject the patient, also her adult child, with an anti-psychotic drug that, in the past, had been effective in treating the patient's severe mental illness. The patient's guardian noted that, without this drug, the patient was sinking further into a psychotic state and the legal guardian was concerned that prolonged psychosis could cause permanent damage and that the patient may never return to their previous level of functioning.

The OIG's investigation revealed that the attending psychiatrist and the patient's treatment team had recommended he/she be administered an injection of a long acting anti-psychotic medication, but that the patient had objected to the injection believing that he/she was a government official and that the drug was intended to cause him/her to divulge national security secrets. In interviews with this patient, the OIG confirmed clinical reports that he/she had persistent and detailed delusions.

The hospital had been advised by the OAG that using restraint to medicate over a patient's objection was a violation of Federal regulations as articulated at 42 CFR § 482.13(e) *Standard: Restraint or seclusion* and, therefore, the facility could not follow the recommendation of the attending psychiatrist and treatment team, who deemed this intervention to be medically necessary, or the instructions of the legal guardian to whom the court had conveyed the specific authority to make medical decisions on behalf of this legally incapacitated person.

The OAG's guidance to the Commonwealth's state facilities is supported by 42 CFR § 482.13(e) and responses to the public comments preceding the promulgation of this regulation published in the *Federal Register* that state in relevant part:

> 42 CFR § 482*(e) Standard: Restraint or seclusion:* All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
>
> Often with the best intentions, a patient or the patient's family may ask for a restraint to be applied...A request from a patient or family member for the application of a restraint which they would consider to be beneficial is not a sufficient basis for the use of a restraint intervention. Regardless of whether restraint use is voluntary or involuntary, if restraint (as defined by the regulation) is used, then the requirements of the regulation must be met....[1]

These two excerpts appear to support the conclusion that, absent an emergency involving "immediate physical safety," a restraint could not be used to administer medication. Based on the foregoing, the OAG has concluded that "restraint can never be consented-to." This interpretation of the regulations eliminates the practice of treatment over objection because the only accepted means of administering non-emergency medication, to a person lacking capacity for informed consent for treatment, consistent with this interpretation, is with an individual's agreement.

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[1] *Federal Register*, Vol. 71, No. 236, *Rules and Regulations*, pg. 71387.

The plain language of § 482(e) provides an important safeguard of the rights of those individuals who have the capacity to participate in an informed medication decision-making process. Without question, all patients have the right to refuse medication – providing that the individual has the capacity to understand the consequences of the decision; however, the OAG's guidance, based on the responses to public comments about the proposed regulation in the *Federal Register,* does not allow for restraint for interventions deemed medically necessary by attending physicians, with the concurrence of the legal guardians or authorized representative, unless the "immediate physical safety" of a patient, staff member, or others is at stake.[2]

An informal survey of the facilities by the OIG revealed that the case profiled above is representative of approximately 10% of the patients residing in state adult behavioral health facilities. Namely, people whose mental illness diminishes their capacity to make informed medical decisions, but who are not presently violent and, hence, do not constitute a threat to anyone's *immediate physical safety.* Under this standard, a passive psychotic person is consigned to a world of persistent and perhaps deepening psychosis, and denied proven interventions deemed medically necessary – even if requested by their AR or guardian, until their *immediate physical safety* is threatened.[3]

The interpretation of the CFRs denying guardians, and even the patients themselves, to authorize restraint to medicate over objection is logical given the language cited above; however, such an interpretation must read silent critical values articulated in the SUMMARY section of 42 CFR Part 482 and repeated throughout in the above referenced *Federal Register* stating that the regulation " ...contains standards that ensure minimum protections of **each patient's physical and emotional** health and safety[4], and codified at § 482.13 *Conditions of participation: Patient's rights*: A hospital must protect and promote **each patient's rights**." [Bold supplied by OIG]

[2] This patient's personal hygiene deteriorates as their mental illness deepens. According to the "immediate physical safety" standard for employing restraint to treat a person, the hospital would be required to wait until a person's urine, or feces, was causing sufficient skin damage to threaten their "immediate" health in order to restrain this person to wash them.

[3] Underlying this treatment approach is the assumption that practitioners will be able to recognize the precise moment when *immediate physical safety* is about to be compromised and intervene with restraint at that moment to create a different outcome for the patient."

[4] *Federal Register*, Vol. 71, No. 236, *Rules and Regulations*, pg. 71378.

The exclusive focus on *immediate physical safety* does not adequately consider a patient's mental health or psychogenic pain and, while the OAG's guidance may protect the rights of most residents of state facilities, it falls short of promoting each patient's rights by potentially consigning some number of passive psychotic individuals to a needlessly protracted severe illness – unless they either consent to medication or present an immediate risk to physical safety.

A number of troubling questions arise from the case profiled above and the controlling OAG interpretation of 42 CFR § 482:

1. Does a patient, capable of making an informed decision about his/her medical care, have the right to formulate an advance directive requesting that hospital providers use restraint to administer anti-psychotic drugs?

2. If an individual creates a valid advance directive, is hospital staff required to honor the patient's directive?

3. If a hospital is not obligated to honor a patient's advance directive requesting to be restrained to administer anti-psychotic drugs, how can this be reconciled with 42 CFR 482.13(b)(3) that contains the following provision:

    > The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with § 489.100 of this part (Definition), § 489.102 of this part (Requirements for providers), and § 489.104 of this part (Effective dates).

In the responses to public comments published in the *Federal Register* concerning 42 CFR 482, the Centers for Medicare and Medicaid Services (CMS) stated that:

> This regulation is not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need appropriate therapeutic doses of medications to improve their level of functioning so that they can actively participate in their treatment.[5]

[5] *Supra*, pg. 71386.

However, the OAG's controlling interpretation of the regulations clearly "interfere[s] with the clinical treatment of patients" by denying a medical restraint to administer "therapeutic doses of medications" to allow passively psychotic patients to "actively participate in their treatment." The contemporary value of "active treatment" rings hollow if a person remains trapped in their psychosis.

The same volume of the *Federal Register* also states that individuals have "the right to be free from restraints of any form that are not **medically necessary**...." [Bold supplied by OIG][6] Yet, the OAG's interpretation prohibits the use of restraint needed to administer treatment that has been deemed *medically necessary* by a patient's treatment team and the attending psychiatrist to relieve psychogenic pain and allow a person to participate in their recovery.

As noted above, the OAG has determined that "restraint can never be consented-to" based on its reading of the *Federal Register* that states in relevant part:

> Often with the best of intentions, a patient or the patient's family may ask for a restraint to be applied...If a need is confirmed, the practitioner must then determine the type of intervention that will meet the patient's needs with least risk and most benefit to the patient. A request from a patient or family member for the application of a restraint which they would consider to be beneficial is not a sufficient basis for the use of a restraint intervention.[7]

In the OIG's opinion, when this provision is read in its entire context, it does not affirm that restraint can never be consented-to. Rather, this provision states that a patient or family member's request for restraint is insufficient until evaluated and endorsed by the treating medical practitioner familiar with innovative and less restrictive alternatives that comply with the provisions of 42 CFR § 482.

The title of 42 CFR § 482 is *Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients Rights* and, as the title suggests, its stated purpose is to protect patients' rights by setting forth the conditions for hospital participation. Thus, this regulation was expressly created to protect and promote patient rights by restricting the actions of hospitals participating in the Medicaid and Medicare programs. In the OIG's view, the interpretation of the OAG is flawed because it

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[6] *Supra*, pg. 71385.

[7] *Supra*. Pg. 71387.

would restrict the rights of a competent patient to enter into an advance medical directive authorizing restraint for treatment. This interpretation also restricts a passive patient's right to be administered medically necessary medications that would allow them to participate in their treatment – until their condition deteriorates to a point threatening their *immediate physical safety.*

Unfortunately, a regulation crafted expressly to limit the prerogatives of health care providers by creating negative covenants to protect hospitalized people has become an instrument that restricts the right of patients to active treatment that could ease their psychogenic pain and allow individuals to more fully participate in their recovery.

Notwithstanding the foregoing discussion, the refusal to provide treatment deemed medically necessary by an attending physician for the health, safety, or welfare of the patient, with the express consent of the individual's legal guardian, satisfies the definition of neglect and abuse as described by the *Code of Virginia* at § 37.2-100:

> "Neglect" means failure by an individual or a program or facility operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, **treatment**, care, goods, or services necessary to the health, safety, or welfare of a person receiving care or treatment for mental illness, mental retardation, or substance abuse.
>
> "Abuse" means any act **or failure to act** by an employee or other person responsible for the care of an individual in a facility or program operated, licensed, or funded by the Department, excluding those operated by the Department of Corrections, that was performed or was failed to be performed knowingly, recklessly, or intentionally, **and that caused or might have caused physical or psychological harm, injury, or death to a person receiving care or treatment for mental illness, mental retardation, or substance abuse.** [Emphasis supplied by OIG]

In discussions with the Attorney General's Office, the OIG was advised that its current interpretation of CFR 42, Part 482 would stand unless advised otherwise by CMS. Therefore, we are petitioning you to assist us in resolving the seeming ambiguity, or the unintended consequences, created by the language of this regulation.

Please advise if you have any questions or require any additional information regarding this issue.

Sincerely,

G. Douglas Bevelacqua
Inspector General
Behavioral Health and Developmental Services.

C: Allyson K. Tysinger, Senior Assistant Attorney General
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