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 September 30, 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 PRACTICE OF STREETING IN VIRGINIA

The OIG was introduced to the term "streeting" during a follow-up in 2010 on the impact to Hampton Roads stemming from the downsizing of ESH. In subsequent inquiries the OIG learned that, while this issue appeared most prevalent in Hampton Roads (HPR V), it also appeared that this practice was occurring throughout the Commonwealth.

According to the HPR V definition, a person is documented as "streeted" when that individual is determined to meet the criteria for a temporary detention order (TDO), but is released from custody because an accepting facility cannot be located to admit the person with mental illness.[1]

There have been understandable objections to the term "streeted", since it does not always accurately characterize the disposition for individuals for whom TDOs were not executed, so the OIG has chosen to reframe this practice as "unexecuted TDOs" to describe the outcome when the system fails to deliver the level of care deemed clinically appropriate.

Beginning July 15, 2011, the OIG and the DBHDS launched a joint statewide initiative designed to study this issue further. All the CSBs and BHAs are participating in this initiative. The goal of this initiative is to provide an objective basis for understanding the extent and contributing factors associated with unexecuted TDOs.

This initiative's instrument for data collection was created with input from the OIG, DBHDS, CSBs and the private hospital association. The survey instrument allows us to document the actual disposition of the individuals in crisis and this drilling-down into each case will provide a greater understanding of what happens to a person meeting TDO criteria, but for whom a temporary detention order is not executed.

The study is designed to identify stress points in service delivery for persons determined to meet TDO criteria by screening professionals. The two key components of this joint review are:

[1] § 37.2-808 of the *Code* lists the criteria for temporary detention including: 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."

*The complete SAR includes a summary of inspections, investigations, and reviews conducted, reports issued and outstanding recommendations.

1. The number of persons identified as meeting the criteria for TDO for which no accepting facility could be located and the TDO was not executed; and,

2. The number of individuals for whom the TDO was executed but the time that it took for a willing facility to be located extended beyond the 6 hour limit established by the *Code*.

A review of the data from the first half of this approximate 3 month initiative, representing the reporting periods from July 15, 2011 through August 25, 2011, revealed that 194 cases meet the two criteria during the 6 weeks interim review.

Southwest Virginia (PPR 3) and Hampton Roads (PPR V) had the largest number of unexecuted TDOs with 21 and 15 respectively. Southwest Virginia has created an *ad hoc* committee to identify the hydraulics driving unexecuted TDOs and will issue a report in December.

In addition to the data collection phase of the study, the Inspector General gathered information from Emergency Services Managers and emergency room physicians in order to understand their unique perspectives on this issue.

The discussions between the IG and emergency room physicians reflected significant overlap with the information provided by the ES Directors around the state. Namely, that the regions of the Commonwealth with a state facility that is able to accept the most challenging TDOs have fewer unexecuted TDOs than those parts of the state where the state facilities lack the capacity to accept TDO admissions.

Also, both ES Directors and emergency room physicians cited the lack of provider consensus concerning medical clearance, and what constitutes appropriate medical screening or assessment, as a recurrent impediment to locating a suitable bed for a person prescreened and determined to meet TDO criteria.

Many of the specific problems discussed by ER physicians were identified and thoughtfully considered by the DBHDS' "Medical Screening and Assessment, Guidance Materials" (March 13, 2007). Fortunately, the research and analytical work necessary to produce better ER outcomes has been completed, and what remains is for the system providers to apply the consensus guidance contained in this 2007 document.

The OIG-DBHDS Report is scheduled for release in December, 2012.

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

In May, 2011, the OIG petitioned the Director of the Centers for Medicare and Medicaid Services (CMS) to clarify the Federal regulations at 42 CFR Part 482.13(e) concerning the use of restraint to medicate over a patient's objection.

The need for this clarification was triggered by a complaint from a legal guardian that her mentally ill adult child, a patient in a state operated behavioral

health facility, was not receiving medically necessary treatment prescribed by the attending psychiatrist. Because this legally incompetent patient refused to agree to the injection and the hospital had been instructed by the OAG that, absent an emergency involving the immediate physical safety of the patient or a staff member, restraint could not be used to administer the prescribed medication.

The Administrator of CMS responded in July confirming that, "…the patient does not have the right to refuse medical treatment; only the patient's representative (as allowed by State law) has the right to make informed decisions regarding care [for a legally incompetent person]."

Dr. Berwick, the Administrator of CMS, further elaborated that, "In such circumstances, it is acceptable under 42 CFR section 482.13(e) for properly trained hospital staff, acting under a restraint order from a physician or practitioner, to use the least restrictive method of restraint in order to safely administer treatment."

The full text of the Federal guidance can be found at Appendix II in the SAR.

QUALITY MANAGEMENT OF COMMUNITY-BASED RESIDENTIAL PROGRAMS

In November representatives from the OIG initiated a statewide review of programs that provide community-based residential services and supports for adult individuals with an intellectual disability. The review focuses on randomly selected community residential services and sponsored residential programs licensed by the Department of Behavioral Health and Developmental Services and Intermediate Care Facilities for the Mentally Retarded (ICFMR).

A focus on a community life for individuals with intellectual disability is embedded in DBHDS mission and vision statements, and the Virginia General Assembly biennium budget for FY10-FY12 reflects a commitment to advancing a life in the community for these individuals.

Currently, more than 1,600 individual sites are licensed to provide community residential living to over 6,000 individuals with intellectual disabilities. The number of licensed sites is certain to grow during the next decade in response to DOJ's 2011 *Findings* that Virginia has "failed to provide service to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs."

The Commonwealth of Virginia's commitment to supporting a life in the community for individuals with intellectual disability necessitates an equally clear commitment to ensuring that individuals receive services and supports of the highest quality.

The OIG review includes six focus areas, of which four are expected to take place on-site: (1) an environmental review, (2) record reviews, (3) interviews of individuals in residence, and (4) interviews of staff present at the time of the review. Two review focus areas may occur on site or may be completed by phone: (5) interview of program leadership and (6) interview of key person(s) in the life of the individual. In

all instances, the identified Case Manager for individuals interviewed will be consulted.

The review is expected to conclude in January with a full report released in early spring 2012.

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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November 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 November 30, 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 ten (10) facilities operated 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

April 1, 2011 to September 30, 2011

Office of the Inspector General

Behavioral Health and Developmental Services

G. Douglas Bevelacqua
Inspector General
November 21, 2011

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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
April 1, 2011 to September 30, 2011[1]

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 shifts. During this semi-annual reporting period, the office conducted 14 unannounced visits at the following facilities:

- Western State Hospital in Staunton
- Commonwealth Center for Children and Adolescents in Staunton
- Southwestern Virginia Mental Health Institute in Marion
- Catawba Hospital in Catawba
- Virginia Center for Behavioral Rehabilitation in Burkeville
- Eastern State Hospital in Williamsburg (3 unannounced visits)
- Piedmont Geriatric Hospital in Burkeville (2 unannounced visits)
- Central State Hospital in Petersburg
- Northern Virginia Mental Health Institute in Falls Church (2 unannounced visits)
- Southern Virginia Mental Health Institute in Danville

The OIG also conducted one announced visit at the Commonwealth Center for Children and Adolescents during this reporting period.

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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 April 1, 2011 to September 30, 2011, are summarized in the SAR In-Brief that can be found on the OIG website at: www.oig.virginia.gov.

SUMMARY OF UPCOMING OIG REPORTS

Commonwealth Center for Children and Adolescents (CCCA)

The OIG conducted an extended inspection at the Commonwealth Center for Children and Adolescents (CCCA) during this reporting period. The inspection primarily focused on facility utilization, staffing patterns, and the use of seclusion and restraint. Summaries of the information in each of the focus areas are provided below.

Background: CCCA is the only inpatient facility operated by the Department of Behavioral Health and Developmental Services (DBHDS) dedicated to the care and treatment of children and adolescents. The overall bed capacity operated by DBHDS was reduced to 48 beds at CCCA following the closing of the 16 bed inpatient adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, Virginia in July 2010. By mission and practice, CCCA is an acute care facility. As such, CCCA is designed to provide comprehensive diagnostic services, crisis stabilization, and intensive short-term treatment.

Facility Utilization: There were 780 admissions to CCCA during FY2011, which represents a 38% increase in the number of admissions that occurred during the previous fiscal year.[2] As an essential component of the state's safety net services, the facility often serves children and adolescents that either have been unsuccessfully treated in less restrictive settings or because the community resources necessary to understand and deal with the presenting crisis situations are not available when and where they are needed.

Due to the acute nature of the services provided, the average length of stay (LOS) for the children served by the facility is 16 days. Highly coordinated discharge planning is crucial to successful outpatient follow-up and service management. The facility works collaboratively with the children and their families, the appropriate community services board, and private providers, as needed, throughout an individual's hospitalization in order to coordinate and facilitate continued service provision after discharge. Sixty-two percent of the children served return to their homes with outpatient services arranged. Children determined to be clinically ready for discharge are often maintained in the hospital because of the limited resources available for a smooth transition to their identified community-based service needs, including access to psychiatrists and more intensive levels of care.

The facility saw a 5% rise in the readmission rate (readmitted within 30 days of discharge) in FY2011. Leadership at the facility attributed the rise in the readmission rate to two factors: 1.) Efforts by the localities to serve the children in their home communities without a

[2] According to information provided by the facility director, there has been a 10% increase in admissions during the first quarter of FY2012 as compared to the same quarter in FY2011.

comprehensive array of services to adequately address their service needs; and 2.) Cutbacks in the approval of expenditures for residential placements through Comprehensive Services Act (CSA) funds.

Staffing Patterns and the Populations Served: Over the past year, CCCA has shifted its approach to unit staffing from a traditional residential programming model to a more clinically integrated one. The new model aligns direct care staff under the nursing structure so that daily operations/activities are supervised by licensed nursing personnel. While the shift to the nursing supervision model has been generally welcomed and supports clinically coordinated staff and resident interactions, the staffing patterns at CCCA continue to reflect the more traditional residential model of approximately 1 staff member for every 4 residents. This ratio does not allow for any flexibility in handling crisis situations, the demands of an ever-shifting therapeutic environment, family visits, and the numerous admissions and discharges.

CCCA serves very diverse and often challenging populations. While the vast majority of individuals admitted to CCCA are determined to have a primary diagnosis of mental illness, a large number of the children and adolescents admitted also have associated behavioral problems. Significant numbers of children served at the facility are dually-diagnosed with mental health and substance abuse (MH/SA) or mental health and intellectual disabilities (MH/ID). In addition, there has been an increase in the number of children served that have dual diagnoses of MH/ID. Approximately 17% of the FY2011 admissions, or 135 individuals, had either MH/ID diagnoses or Intellectual Disability/Autism Spectrum Disorder (ID/ASD) diagnoses.

Another population that presents unique challenges for the facility is the forensic population. Clinical and administrative staff informed the OIG that continuous risk assessments are necessary to mitigate a variety of risk factors associated with serving diverse populations within the acute care structure, particularly as it pertains to the forensic population. Higher functioning adolescents from correctional settings often prey on the more vulnerable children, are less tolerant of the symptoms of their peers who are actively psychotic or cognitively impaired, and often bring their “gang” mentality to the setting, which in some cases has resulted in “gang-related rivalries” being acted out in the facility. Administrative staff reported that peer-to-peer aggression is often a consequence of the mixing of the forensic and other populations.

Seclusion and Restraint: Data provided by the facility suggests that the initiatives undertaken by CCCA to reduce the use of hands-on interventions have had a positive effect. The data provided and statements made by members of the leadership team support the following:

- Because of dramatically increased admissions and patient acuity levels, the use of Seclusion and Restraint (SR) has increased 6.8% in FY2011 compared to FY2010. However, as outlined in interviews and in the data collected, for FY2011 the mean use of restrictive interventions per admission has decreased 24% compared to FY2010 (1.7 for FY2011 compared to 2.23 for FY2010).

- Compared to FY2009, the use of SR was reduced by 1.5% and the mean SR use per admission was reduced by 25% (1.7 for FY2011 compared to 2.26 for FY2009).

The full report, OIG No. 199-11, is currently under review by DBHDS and will be posted to the OIG website in December 2011. To request that a copy of the report or a notice of posting be forwarded to your e-mail address, please notify the office at oig@oig.virginia.gov

Review of Intellectual Disability Residential Services

In November representatives from the OIG initiated a statewide review of programs that provide community-based residential services and supports for adult individuals with an intellectual disability. The review focuses on randomly selected community residential services and sponsored residential programs licensed by the Department of Behavioral Health and Developmental Services and Intermediate Care Facilities for the Mentally Retarded (ICFMR).

A focus on a community life for individuals with intellectual disability is embedded in DBHDS' mission and vision statements, and the Virginia General Assembly biennium budget for FY10-FY12 reflects a commitment to advancing a life in the community for these individuals.

- "The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals". (From DBHDS Mission)

- "We envision an individual-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation in all aspects of community life, including work, school, family and other meaningful relationships". (DBHDS Vision)

- $30 million in Trust Fund: "For the purpose of financing a broad array of community-based services, including up to six hundred ID Home and Community Based Waiver slots, one-time transition costs for community placements, appropriate community housing, and other identified community services that may not be covered through the waiver program, for the purpose of transitioning

individuals with mental retardation from state training centers to community-based settings". (FY10-FY12 budget)

Currently, more than 1,600 distinct sites are licensed to provide community residential living to over 6,000 individuals with intellectual disability and the number of licensed sites is expected to grow during the next decade. The commitment from the Commonwealth of Virginia to supporting a life in the community for individuals with intellectual disability necessitates an equally clear commitment to ensuring that individuals receive services and supports of the highest quality.

The OIG review includes six focus areas, of which four are expected to take place on-site: (1) an environmental review, (2) record reviews, (3) interviews of individuals in the residence, and (4) interviews of staff present at the time of the review. Two review focus areas may occur on site or may be completed by phone: (5) interview of program leadership and (6) interview of key person(s) in the life of the individual. In all instances, the identified Case Manager for individuals interviewed will be consulted.

The review is expected to conclude in January with a full report released in early spring 2012.

Review of Behavioral Health Forensic Services

The OIG completed a review of DBHDS forensic services in the state behavioral health facilities during the period February – June 2011 in order to determine if individuals classified as "forensic" residents in state facilities are receiving services that reflect the DBHDS commitment to recovery and person-centeredness and if forensic services are delivered in a consistent manner across the facilities.

The OIG conducted the forensic review utilizing six separate activities. The activities included review of written facility material and record documentation; interview of treatment providers and service recipients; review of current forensic services planning efforts; and consultation with DBHDS forensic office staff.

Beyond the primary focus areas, OIG staff used on-site time to identify treatment or record management practices that reflected the facility's commitment to creating a person-centered recovery experience. We sought to identify any unique facility level practices reflecting a commitment to recovery or person-centered practices that could be considered for broader application, and solicited improvement input from program level staff, individuals that were current or past forensic program residents, and DBHDS Central Office leaders directly involved with overall forensic programming.

*Background***:** The OIG focus on DBHDS forensic services and the measure of treatment alignment with recovery and person-centered values stemmed from several factors:

- DBHDS has identified a growing demand for state operated beds for the forensic population. Thirty six percent (36%) of all adult mental health bed utilization in fiscal year 2010 was attributed to individuals admitted under a forensic status.
- The length of stay (LOS) for individuals in DBHDS forensic programs, especially individuals treated pursuant to Not Guilty by Reason of Insanity (NGRI) admissions, exceeds LOS for civil admissions. NGRI individuals are often in DBHDS facilities for five to six years.
- The growth in forensic bed utilization impacts access to civil beds for individuals who cannot be treated in less restrictive community-based settings.
- Individuals treated in DBHDS forensic programs carry a level of stigma that exceeds most other populations served in state facilities, as they face the stigmas that exist for individuals with serious mental illness and stigma associated with their involvement with the criminal justice system. As such, there are significant challenges in providing recovery and person-centered services to these individuals.

DBHDS leadership is now considering the findings and recommendations generated from this review. A full report of review findings and recommendations will be released in December 2011.

SUMMARY OF SIGNIFICANT PROBLEMS, ABUSES, AND DEFICIENCIES

Update on the Practice of "Streeting" In the Commonwealth

The OIG was introduced to the term "streeting" during a follow-up in 2010 on the impact to Hampton Roads stemming from the downsizing of ESH. In subsequent inquiries the OIG learned that, while this issue appeared most prevalent in Hampton Roads (HPR V), it also appeared that this practice was occurring throughout the Commonwealth. According to the HPR V definition, a person is documented as "streeted" when that individual is determined to meet the criteria for a temporary detention order (TDO), but is released from custody because an accepting facility cannot be located to admit the person with mental illness.[3]

[3] § 37.2-808 of the *Code* lists the criteria for temporary detention including: 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."

There have been understandable objections to the term “streeted”, since it does not always accurately characterize the disposition for individuals for whom TDOs were not executed, so the OIG has chosen to reframe this practice as “unexecuted TDOs” to describe the outcome when the system fails to deliver the level of care deemed clinically appropriate.

As we reported in our presentation to the Joint Committee in June 2011, it is important to note that the failure to execute a TDO does not necessarily mean that people were literally put on the street. Although individual outcomes are difficult to track, the OIG is convinced that emergency service staffs are diligent and pursue a range of alternatives to keep these individuals as safe as possible. The outcome for an individual who meets the criteria for a TDO that could not be executed might include: seeking admission to a crisis stabilization program if they are capable of accepting a TDO; when available, developing a safety plan with family members, that includes strategies for the individual to be seen for intensive services through the CSB; or seeking an agreement for the individual to stay in the emergency room, if the crisis is after-hours, with intensive CSB supports to follow the next day. Also, crisis workers reported that charges might be filed, if warranted, so that a person could be retained in a safe correctional setting rather than be released.

Beginning July 15, 2011, the OIG and the DBHDS launched a joint statewide initiative designed to study this issue further. All the CSBs and BHAs are participating in this initiative. The goal of this initiative is to provide an objective basis for understanding the extent and contributing factors associated with unexecuted TDOs. This initiative’s instrument for data collection was created with input from the OIG, DBHDS, CSBs and the private hospital association. The survey instrument allows us to document the actual disposition of the individuals in crisis and this drilling-down into each case will provide a greater understanding of what happens to a person meeting TDO criteria, but for whom a temporary detention order is not executed.

The study is designed to identify stress points in service delivery for persons determined to meet TDO criteria by screening professionals. The two key components of this joint review are:

1. The number of persons identified as meeting the criteria for TDO for which no accepting facility could be located and the TDO was not executed; and

2. The number of individuals for whom the TDO was executed but the time that it took for a willing facility to be located extended beyond the 6 hour limit established by the *Code*.

The OIG and DBHDS have designated these key components as quality indicators by which to measure the performance of the chain of providers involved in the process. Each

scenario represents a failure of the service delivery system in meeting the established statutory requirements outlined for persons detained under an Emergency Custody Order (ECO).

The review was designed so the initial data is routed through the regional managers for the 7 planning partnership regions (PPR) so that emerging patterns, specific to each region, can be recognized and considered. An interim summary of the results by PPR is attached at Appendix I. In addition to the data collection phase of the study, the Inspector General gathered information from Emergency Services Managers and emergency room physicians in order to understand their unique perspectives on this issue.

A review of the data from the first six weeks of this approximate 3 month initiative, representing the reporting periods from July 15, 2011 through August 25, 2011, revealed the following:

- During the six-week period of this interim review, there were 194 cases meeting the two criteria established for the study.

- Of the total cases, 119 or 61.34% began with the issuance of an emergency custody order (ECO.

- 145 of the cases involved individuals for whom a TDO was executed but exceeded the 6-hour time limit established for ECOs in VA Code.

- 49 involved individuals who met the criteria for a TDO, but a TDO was not executed. Reasons why a TDO was not executed vary and do not mean that all of the individuals were released without a safety plan or alternative intervention.

- The majority (63%) of the initial contacts or pre-screenings occurred in hospital emergency rooms. The remaining contacts took place in hospital psychiatric units and other community settings including CSB offices and local law enforcement facilities.

The IG attended regional meetings across the state and met with Emergency Services Managers. These meetings and the bi-monthly regional outcome report have raised the consciousness of regional issues that were largely off-the-radar. The ES Directors reported that, prior to the OIG interest in this issue, they were not aware that the problem with unexecuted TDOs was a statewide problem. This outcome alone makes this project a successful venture in recognizing areas within the TDO process where improvements can be made regionally and around the state.

The discussions between the IG and emergency room physicians reflected significant overlap with the information provided by the ES Directors around the state. Namely, that the regions of the Commonwealth with a state facility that is able to accept the most challenging TDOs have fewer unexecuted TDOs than those parts of the state where the state facilities lack the capacity to accept TDO admissions.

Also, both ES Directors and emergency room physicians cited the lack of provider consensus concerning medical clearance, and what constitutes appropriate medical screening or assessment, as a recurrent impediment to locating a suitable bed for a person prescreened and determined to meet TDO criteria. Many of the specific problems discussed by ER physicians were identified and thoughtfully considered by the DBHDS' "Medical Screening and Assessment, Guidance Materials" (March 13, 2007). Fortunately, the research and analytical work necessary to produce better ER outcomes has been completed, and what remains is for the system providers to apply the consensus guidance contained in this 2007 document.

Initial impressions from this preliminary review included the following:

- The issue is a statewide concern.

- The data reveals that the recently established safety net bed admissions process at ESH has been used to assist with persons in HPR V, but that as a region HPR V still has the second highest number of unexecuted TDOs statewide.

- Many of the cases in this preliminary review involve individuals with complicated psychiatric and medical histories and the resulting need for medical clearance contributes to a delay in executing the TDO in a timely manner.

- A general lack of communication between the attending ER physicians and admitting physicians in both the private and state facilities contributes to the delay.

- For the state facilities, the number of persons who are ready for discharge but cannot be placed because of limited community and/or funding resources decreases the number of available beds for admissions.[4]

- In reviewing the data for the initial six weeks of the study, the two regions where this practice was most prevalent were in Hampton Roads and Southwest Virginia. The downsizing of ESH exacerbated this problem in Hampton Roads, but the data

[4] This issue is currently under review by the OIG. A completed report is anticipated by January 2012.

reveals that something is happening in Southwest Virginia that resulted in unexecuted TDOs for approximately 20 individuals.

In conversation with the leadership at SWVMHI, we have anecdotal reports that they are experiencing capacity problems due to a recent increase in the length of stay of residents. This issue will require more study to understand the dynamics driving the spike in numbers of persons meeting TDO criteria for whom a private or public facility could not be located.

Update on CMS Clarification on the Use of Restraint to Medicate Over a Patient's Objection

In May, 2011 the OIG petitioned the Director of the Centers for Medicare and Medicaid Services (CMS) to clarify the Federal regulations [42 CFR Part 482.13(e)] concerning the use of restraint to medicate over a patient's objection.

The need for this clarification was triggered by 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 legally incompetent patient refused to agree to the injection and the hospital had been instructed by the OAG that, absent an emergency involving the immediate physical safety of the patient or a staff member, restraint could not be used to administer the prescribed medication.

The Director of CMS responded in July confirming that, "…the patient does not have the right to refuse medical treatment; only the patient's representative (as allowed by State law) has the right to make informed decisions regarding care [for a legally incompetent person]." Dr. Berwick further elaborated that, "In such circumstances, it is acceptable under 42 CFR section 482.13(e) for properly trained hospital staff, acting under a restraint order from a physician or practitioner, to use the least restrictive method of restraint in order to safely administer treatment."

The full text of the Federal guidance can be found at Appendix II.

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 September 30, 2011.

Over the past two years, there have been four outstanding active findings which have a significant impact on the care and treatment of the individuals served by the DBHDS facility system. Each of these issues required that DBHDS update policies and procedures or establish protocols that would assure consistency in practice across the service delivery system. To-date these policies, procedures, and/or protocols have not been completed.

1. 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 history of bringing charges against their patients that exceeded that of all the other facilities combined. A panel of clinical specialists created by DBHDS reviewed the practices of this facility and made recommendations for changes. In its most recent update, DBHDS indicated the following:

> *The revised Departmental Instruction (DI) was developed as reported to the OIG in July 2011. While the DI as scheduled to be published in the fall of 2010, it was not due to staffing shortages at central office. It has since been revived, reviewed by 85 clinical and quality assurance leaders at a statewide meeting of all (ID and MH) facilities on March 3, 2011 and has been submitted for OAG review. It is expected to be published as soon as the OAG review is completed.*

As of September 30, 2011, the OIG has not received a copy of the revised DI nor has it been posted in the DBHDS Departmental Instructions Manual.

2. Protocols Governing Dental Services in State-Operated Training Centers:
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 was 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. This has not been completed.

3. Guidelines Governing the Use of Overtime:

One of the recommendations made by the OIG in its 2010 report regarding the excessive use of overtime in a state-operated training center was for DBHDS' Office of Human Resources to issue guidance to all facilities regarding the use of mandatory vs. voluntary overtime with a focus on the number of consecutive hours an employee could work and the number of overtime shifts per week were considered acceptable for safety reasons. In September 2011, DBHDS informed the OIG of its intent to issue guidance regarding the number of hours that would be considered "excessive" in the near future. This has not been completed.

4. Staff to Resident Ratios:

Following concerns identified by the OIG in an investigation of staff overtime and safety standards around staff to resident ratios, DBHDS informed the OIG of its intent to develop guidelines for appropriate staffing patterns based on the treatment needs of the persons served. This process has been delayed until DBHDS fills the Assistant Commissioner for Quality Improvement position.

SUMMARY OF OUTSTANDING RECOMMENDATIONS: DIVISION OF BEHAVIORAL HEALTH SERVICES:

Facility System:

Environmental risk assessment: The OIG has consistently discussed an on-going environmental risk factor with DBHDS, which has been outstanding for almost two years. This issue was re-addressed with DBHDS in March following a second environmental safety update conducted by the OIG regarding the Hancock Geriatric Treatment Center at ESH. Reviews by two different teams cautioned the facility that changes were needed in the environment to assure the safety of persons served. At that time, the OIG was informed that this issue would be taken under review by the facility director and the OIG informed of

planned changes. This issue was raised again in September 2011 following the suicide of a patient in another behavioral healthcare facility. The facility director informed the OIG, at the end of this reporting cycle, that a plan to remove the identified environmental risks had been initiated with anticipated completion of this process by the end of CY2011. This finding will remain active until all the risks have been addressed.

Community Studies

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. The full implementation that was scheduled to occur by June 2011 did not occur.

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

It has been a little over three years since the Department of Justice (DOJ) first announced its intent to conduct an investigation at Central Virginia Training Center (CVTC) in Lynchburg to assess Virginia's compliance with the *Americans with Disabilities Act* (ADA) of 1991. The ADA represents a national commitment towards the depopulation of institutions that provide care and treatment to persons with intellectual disabilities. This commitment was affirmed in 1999 by the U.S. Supreme Court in its decision in *Olmstead et al v L.C. et al.*

In February 2011, a findings letter was issued by the DOJ that concluded the Commonwealth of Virginia "*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."*

Settlement agreements are mechanisms used by the DOJ to achieve greater access for persons with disabilities in situations where violations of the ADA are substantiated, as was in the case at CVTC, specifically, and across the Commonwealth's ID facility system in regards to the effective discharge of individuals. Within the general rules governing lawsuits

bought by the federal government, the DOJ may not file a lawsuit until it has first attempted to settle the dispute through negotiations.[5] The OIG was informed that DBHDS and the DOJ are currently actively engaged in what is hoped to be the final stages of negotiating a settlement agreement.

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

Community Capacity

- *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.*

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.*

[5] Department of Justice_ CRIPA Enforcement and Special Litigation Unit website.

The OIG continues to actively monitoring 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.

CVTC ACTION PLAN: 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.

CVTC continues refining its plan of continuous improvement for achieving best practices within the facility in a number of key areas such as active treatment, discharge planning, and coordinated person-centered services across disciplines. This plan, which was initially designed to address the issues identified by the DOJ, has developed into targeted measurable activities to guide quality improvement initiatives in each of these key focus areas. The OIG obtained a status update of activities in September 2011. The update summarizes the specific activities undertaken by the facility and strives to link service provision with the key provisions of the ADA and the *Olmstead* Decision.

SYSTEMIC ACTION PLAN: As reported in the last OIG Semi-Annual Report, DBHDS developed two new positions to provide additional oversight to its DOJ compliance process. The OIG had an opportunity to obtain an update of activities accomplished by these individuals since their positions were created. The activities include, but are not limited to, the following:

- The Training Center Operations Manager is 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.
    - A team, under the direction of the Training Center Operations Manager, is visiting each training center to meet with key staff and get their input on the strengths and areas of needed improvement at each setting and within the region. The goal is to develop a continuous quality improvement plan tailored for each setting that will enhance services and facilitate community integration.
    - The Training Center Operations Manager has been meeting with the CSB representatives and will provide additional support in reviewing regional trends and develop action plans towards successful transitions of persons residing in the institutions deemed ready for discharge.

- The Training Center Operations Manager has revised the Discharge Coordinator role to ensure consistency among the training centers.

- In conjunction with DBHDS Human Resources, the Training Center Operations Manager provided expertise towards the hiring of additional CO staff that will be located at the training centers to supervise quality activities, such as monitoring facility discharge targets and analyzing trends and data for post-discharge success.

- The Family Resource Consultant position focuses on and facilitates the education of families about community options.

    - The person in this position has become a visible presence around the state conducting trainings and presentations to a variety of organizations, including parent associations, CSBs and regional workgroups.

    - The Family Resource Consultant has supported three of the training centers to identify and focus on concerns related to community capacity.

    - The Family Resource Consultant has collected stories of successful transitions from all of the training centers for use in future presentations.

    - The Family Resource Consultant has also been developing a mentoring process so that families of members in the community can support other families as they face their concerns and navigate the process of supporting their loved one in transitioning to community settings.

    - The Family Resource Consultant is developing a survey to the community so that objective data can be maintained as a source of feedback to quality improvement initiatives.

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

    - 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.

Enhancing Community Transitions

This project had two phases. The OIG began tracking transitional services to 25 individuals who were discharged from the state training centers during either the end of 2010 or the beginning of 2011; five individuals from each facility. Contacts with case managers and family members have been completed. Site visits to each setting is scheduled to occur during the next six months to assess the success of each individual's transition. In order to assess overall transition services, members of the OIG staff participated in a system-wide conference call with the training centers' Discharge Coordinators on June 23, 2011. Each coordinator was asked in advance to provide the OIG with activities specifically initiated at each facility designed to enhance discharge efforts as well as identify areas were improvements are needed.

Identified Systemic Strengths: Even though the types and number of activities varied depending on the identified needs at both the facility and regional level, there were a number of activities that were identified as occurring system-wide. Among the activities are the following:

- The coordinators and other designated staff are working with public and private providers to educate staff regarding the facility settings and identifying support services offered by the training centers for transitioning individuals.

- Each facility has provided training opportunities for direct care staff regarding community options so that they can be more confident in discussing discharge options and processes with family members. This is very important because most visiting family members have greater exposure to direct care staff than other disciplines.

- Discharge Coordinators work with other staff members to provide transition and post-discharge services to receiving providers. For example, CVTC will work with providers to make sure that the necessary adaptive equipment utilized by an individual is in place in the home – sometimes even loaning equipment, if needed during the initial transition period.

- Facilities had either completed or were organizing Provider Fairs, which allows family members and residents and opportunity to meet with potential service providers so they can have a good understanding of the options available to them and the services they provide. The provider fair at Southside Virginia Training Center held in May 2011 had approximately 60 providers attend.

Areas of Needed Improvements: During this project, the discharge coordinators compiled a list of barriers to successful community integration. Among the areas identified are the following:

- There continues to be an occasional problem with coordinating Medicaid benefits for individuals transitioning from the facility to the community because of occasions when the individual is still coded as a resident at the state facility during trial visits and the provider cannot be paid.

- Family resistance to community placement remains one of the biggest barriers in spite of educational efforts.

- Limited community-based professional resources, such as access to behavioral consultation, physical and occupational therapists and licensed nursing personnel, present a unique challenge for both the residents and providers. The coordinators also report that there are limited numbers of community-based physicians with experience working with and specialized knowledge of persons with intellectual disabilities.

- The coordinators reported that there is a need to more case management oversight and support coordination for transitioning individuals, particularly for persons in community-based intermediate care facilities who do not have case management services provided by the community services boards.

- There is a general lack of both residential and support services for individuals, but this is particularly true in the more rural regions of the state. Employment and day support services are needed. Increased options for community-based respite services would decrease the use of state-operated beds for this purpose.

- The discharge coordinators would like greater access to licensing concerns so that providers that are experiencing problems addressing the needs of the residents are known prior to placement consideration so that informed decisions on behalf of the residents can be made.

OIG DATA MONITORING

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, 427 critical incidents related to injuries and other areas of risk were reported to the OIG through the PAIRS database. Of these incidents, 221 (52%) incidents occurred in the state-operated training centers and 206 (48%) occurred in the state-operated behavioral health facilities. The OIG reviewed each of the 427 critical incident reports forwarded by DBHDS with an additional level of inquiry and follow up conducted on 75, 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 42 deaths in the state-operated facilities from 4/1/11 to 9/30/11; 13 of the deaths occurred in the training centers and 29 deaths were reported in the behavioral health facilities. All of the 38 autopsies forwarded by the Medical Examiner's office for this period were reviewed.

Complaints and Requests for Information/Referrals

The OIG responded to 25 complaints and requests for information/referrals from citizens, service recipients, and employees. Of these contacts, 16 were complaints/concerns and 9 were requests for information/referrals.

REVIEW OF REGULATIONS, POLICIES AND PLANS

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

State Board Policies

Policy 2011(ADM) 88-3	*Naming of Buildings, Rooms and Other Areas at State Facilities*
Policy 3000(CO) 74-10	*Department Employee Appointments to Community Services Boards*
Policy 5006(FAC) 86-29	*Razing of Dilapidated Buildings*
Policy 5008(FAC) 87-12	*Accreditation/Certification*
Policy 6005 (FIN) 94-2	*Retention of Unspent State Funds by Community Services Boards*

OTHER 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 presentations regarding the work of the office or served as the guest speaker:

- Joint Health Commission
- Senate Finance Committee
- KOVAR 2011
- Presentations to various regional CSB organizations on unexecuted TDOs

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

- VACSB Spring Conference
- National Inspectors General Certification Course
- Person-centered Thinking Training

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
- Community Services Boards and their Regional Management Meetings

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

This concludes the Semi-Annual Report of the Inspector General required by *The Code* § 37.2-425 covering the period April 1, 2011 to September 30, 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.

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

Appendix I

Breakdown by Region

Region	> 6 Hrs	"Streeted"
PPR 1 (NW Virginia)	20	4
PPR 2 (NOVA)	10	4
PPR 3 (SW Virginia)	26	21
PPR 4 (Central Virginia)	17	3
PPR 5 (Hampton Roads)	35	15
PPR 6 (South Virginia)	7	2
PPR 7 (Catawba Region)	30	0
Totals	**145**	**49**

Appendix II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL 2 1 2011

G. Douglas Bevelacqua
Inspector General
Behavioral Health and Developmental Services
Commonwealth of Virginia
Office of the Inspector General
P.O. Box 1797
Richmond, VA 23218

Dear Mr. Bevelacqua:

Thank you for your letter requesting clarification concerning the Medicare hospital regulations governing use of restraints.

The restraint and seclusion requirements at 42 CFR section 482.13(e) do not prohibit the use of restraints in hospitals. Instead, the regulation establishes the patient's right to be free from inappropriate restraint or seclusion, and lays out basic protections in the event that these interventions are needed.

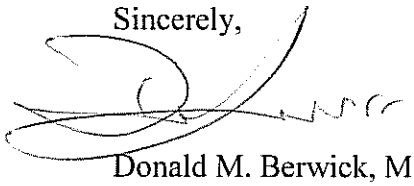
In certain circumstances, a patient may consent to an injection or procedure, but may not be able to hold still for the injection, or cooperate with the procedure. In such circumstances, and at the patient's request, staff may "hold" the patient in order to safely administer an injection or to conduct a procedure. This is not considered a restraint. On the other hand, the application of force to physically hold a patient who is resisting administration of a medication is considered restraint and, as such, may only be used in circumstances that meet the regulatory requirements.

In a situation, such as the case described in your letter, in which a hospital patient has been legally deemed incompetent, the patient does not have the right to refuse medical treatment: only the patient's representative, as determined under State law, can make a decision on behalf of the patient to consent to or refuse medical treatment. Under 42 CFR section 482.13 (b)(2), the patient's representative (as allowed under State law) has the right to make informed decisions regarding care, and to request or refuse treatments. When the patient's representative has consented to medical treatment, including administration of an injection against the incompetent patient's will, and the patient physically resists the treatment, despite the use of non-restraint types of interventions, there is a risk of immediate physical injury to the patient. In such circumstances, it is acceptable under 42 CFR section 482.13(e) for properly trained hospital staff, acting under a restraint order from a physician or practitioner, to use the least restrictive method of restraint feasible in order to safely administer treatment.

We stress that, as in all cases of application of restraints, the individual patient's circumstances must be assessed, and there must be a determination that less restrictive interventions are ineffective in protecting the patient or staff from harm. It is essential that the hospital use an individualized approach that is in the best interest of the patient and promotes the patient's health, safety, dignity, self-respect, and self-worth.

Thank you for your inquiry, which has provided us the opportunity to clarify this very important aspect of a hospital patient's rights.

Sincerely,



Donald M. Berwick, M.D.

cc:
Allyson K. Tsinger, Senior Assistant Attorney General
Chief Mental Health/Health Services Division
Martin Kent, Chief of Staff for Governor McDonnell
James A. Stewart, III, Commissioner, DBHDS