OFFICE OF THE STATE INSPECTOR GENERAL

Report to DBHDS Interim Commissioner
Jack Barber, MD

FY 2015 Unannounced Inspections of the Adult Behavioral Health Facilities and Hiram Davis Medical Center
May 2016

June W. Jennings, CPA
State Inspector General

Report No. 2015-BHDS-006

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

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May 5, 2016

Jack Barber, MD, Interim Commissioner
Virginia Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23219

Dear Dr. Barber:

The Office of the State Inspector General (OSIG) performed unannounced inspections of the state-operated adult behavioral health facilities and Hiram Davis Medical Center (HDMC) for Fiscal Year (FY) 2015 pursuant to the *Code of Virginia (Code)* § 2.2-309.1[B](1) and respectfully submits this report as required by *Code* § 2.2-309.1[B](4).

The purpose of these inspections was to assess the impact of *Code* § 37.2-809.1[B], hereafter referred to as the safety net law, on the adult behavioral health facilities, HDMC, and the staff and individuals served in these settings. This focus area was selected for the following reasons:

1. The 2014 safety net law was a significant piece of behavioral health legislation impacting the admission process for the entire state and preventing the DBHDS-operated behavioral health facilities from having the ability under any circumstances to fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility agrees to accept that individual.
2. The provisions of the law did not take into account the programmatic, staffing, and financial resources state-operated facilities possess in order to provide for safe, high quality care for those individuals and no other review has been completed to assess the impact of making state-operated facilities the treatment setting of last resort.

OSIG determined that while the safety net law has ensured individuals meeting temporary detention criteria are able to be admitted to a hospital bed, the implementation of the law has had a profound impact on the state-operated adult behavioral health facilities, HDMC, and the staff and individuals served. In summary, OSIG found the following:

- Adult and geriatric civil temporary detention order (TDO) admissions, discharges, and utilization rates in the behavioral health facilities increased significantly in FY 2014 and FY 2015.
- A correlation was found between increased admissions, discharges, and utilization rates and adverse events in the behavioral health facilities.
- The impact of the safety net law on the behavioral health facilities, HDMC, and the staff and individuals served was not fully planned for prior to its implementation, nor responded to in the months since.

By copy of this letter, OSIG is requesting that agency management provide a corrective action plan within 30 days to address this report's recommendations.

OSIG would like to express our appreciation for the assistance DBHDS, the adult behavioral health facilities and HDMC's leadership and staff provided during these inspections. If you have any questions, please call me at (804) 625-3255 or email me at june.jennings@osig.virginia.gov. I am also available to meet with you in person to discuss this report.

Respectfully,

June Jennings, CPA
State Inspector General

CC: Paul Reagan, Chief of Staff to the Governor
Suzette Denslow, Deputy Chief of Staff to the Governor
Dr. William A. Hazel, Jr., Secretary of Health and Human Resources
Daniel Herr, DBHDS Assistant Commissioner of Behavioral Health Services
Delegate John M. O'Bannon, III, Chair of the Joint Commission on Health Care
Senator L. Louise Lucas, Vice Chair of the Joint Commission on Health Care

TABLE OF CONTENTS

Executive Summary

The Office of the State Inspector General (OSIG) performed the FY 2015 unannounced inspections at the eight adult behavioral health facilities and Hiram Davis Medical Center (HDMC) operated by the Department of Behavioral Health and Developmental Services (DBHDS) as required by *Code of Virginia (Code)* § 2.2-309.1[B](1)(4). The objective for this series of unannounced inspections was to assess the impact of *Code* § 37.2-809.1[B], hereafter referred to as the "safety net law," on the adult behavioral health facilities, HDMC, and the staff and individuals served in these settings. This report contains the observations and recommendations made as a result of the inspection process.

The focus of these inspections was selected for the following reasons:

- The 2014 safety net law was a significant piece of behavioral health legislation impacting the admission process for the entire state and preventing the DBHDS-operated behavioral health facilities from having the ability under any circumstances to fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility agrees to accept that individual.
- The provisions of the safety net law did not take into account the programmatic, staffing, and financial resources state-operated facilities possess in order to provide for safe, high quality care for those individuals and no other review has been completed to assess the impact of making state-operated facilities the treatment setting of last resort.

OSIG determined that while the safety net law has ensured individuals meeting temporary detention criteria are able to be admitted to a hospital bed, the implementation of the law has had a profound impact on the state-operated adult behavioral health facilities, HDMC, and the staff and individuals served.

To improve the quality of services and outcomes, OSIG makes the following recommendations:

1. The DBHDS-operated behavioral health facility Chief Executive Officers, in partnership with the medical staffs, chief nurse executives, and DBHDS Central Office, review current facility programming and scope of services for each facility and across the system and revise them to address regional changes in admissions, discharges, and patient mix that have occurred since the implementation of the safety net law. Any changes requiring funding or approval of the General Assembly should be submitted accordingly.

2. The Board of Nurse Executives should analyze current facility operations, patient mixes, acuity, work force demographics, revisions to the number of nursing hours per patient day, and required skills sets to determine if facility master staffing plans require revision in response to changes incurred following the implementation of the safety net law. Recommendations should be presented to DBHDS for consideration and utilized to request additional funding from the General Assembly to support any required staffing increases.

Purpose and Scope of the Review

OSIG performed unannounced inspections at the DBHDS-operated adult behavioral health facilities and HDMC, pursuant to *Code* § 2.2-309.1[B](1)(4), whereby the State Inspector General shall have the power and duty to:

> "1. Provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities, in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services. The State Inspector General shall provide oversight and conduct announced and unannounced inspections of state facilities and of providers, including licensed mental health treatment units in state correctional facilities, on an ongoing basis in response to specific complaints of abuse, neglect, or inadequate care and as a result of monitoring serious incident reports and reports of abuse, neglect, or inadequate care or other information received. The State Inspector General shall conduct unannounced inspections at each state facility at least once annually;" and
>
> "4. Keep the General Assembly and the Joint Commission on Health Care fully and currently informed by means of reports required by § 2.2-313 concerning significant problems, abuses, and deficiencies relating to the administration of the programs and services of state facilities and of providers, including licensed mental health treatment units in state correctional facilities, to recommend corrective actions concerning the problems, abuses, and deficiencies, and report on the progress made in implementing the corrective actions."

The purpose of the inspections was to assess the impact of the 2014 safety net law on the DBHDS-operated adult behavioral health facilities, HDMC, and the staff and individuals served; and to report the results to legislators, policy makers, and DBHDS in order that they utilize the observations and recommendations to inform facility operations, legislative changes, and funding decisions going forward.

The inspections were not designed to assess the impact of the safety net law on community or private providers, or to review other mental health laws enacted by the Virginia General Assembly during the 2014 and 2015 sessions. While some of the data is presented as being associated with the implementation of the safety net law, direct causation was beyond the scope of the inspections. The focus of these inspections was selected for the following reasons:

- The 2014 safety net law was a significant piece of mental health legislation impacting the admission process for the entire state and preventing the DBHDS-operated behavioral health facilities from having the ability under any circumstances to fail or refuse to admit an individual who meets the criteria for temporary detention unless an alternative facility agrees to accept that individual.

- The provisions of the safety net law did not take into account the programmatic, staffing, and financial resources state-operated facilities possess in order to provide for safe, high quality care for those individuals, and no other review has been completed to assess the impact of making state-operated facilities the treatment setting of last resort.

Background

Effective July 1, 2014, changes in Virginia statutes relevant to the involuntary commitment of individuals to behavioral health facilities became law. *Code* § 37.2-809.1[B] mandates that:

> "Under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention pursuant to § 37.2-809 unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual."

Although the law did not go into effect until July 1, 2014, DBHDS-operated behavioral health facilities began feeling its impact in early spring of that year in anticipation of legislative changes being signed into law.

Prior to July 1, 2014, DBHDS-operated behavioral health facilities possessed — by existing legislation — the ability to decline an admission based upon ability to safely provide high quality services to an individual if that individual presented with diagnoses, risks, or clinical needs beyond the capability of the facility, its staff, or available space. Additionally, if an individual was detained under an emergency custody order (ECO) for the purpose of a prescreening evaluation, he or she could not be held against their will beyond the statutorily defined duration of the ECO, even if the prescreening evaluation determined the individual was a danger to self or others. On those occasions when a TDO was not executed, the individual had the legal ability to leave the setting where the prescreening evaluation occurred, which could potentially place the individual and/or others at risk. The changes in the safety net law now prevent the individual from leaving and guarantee placement at a state-operated facility unless another willing and capable facility is located before the ECO expires.

DBHDS Adult Behavioral Health Facilities

DBHDS operates eight adult behavioral health facilities: Catawba Hospital (CAT) in Catawba, Central State Hospital (CSH) in Petersburg, Eastern State Hospital (ESH) in Williamsburg, Northern Virginia Mental Health Institute (NVMHI) in Falls Church, Piedmont Geriatric Hospital (PGH) in Burkeville, Southern Virginia Mental Health Institute (SVMHI) in Danville, Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, and Western State Hospital (WSH) in Staunton.

The DBHDS' Comprehensive State Plan 2014-2020[1] maintains that state behavioral health facilities:

> "… provide highly structured intensive inpatient services, including a range of psychiatric, psychological, psychosocial rehabilitation, nursing, support, and ancillary

[1] Virginia Department of Behavioral Health and Developmental Services, Comprehensive State Plan 2014-2020, http://www.dbhds.virginia.gov/library/quality%20risk%20management/opd-stateplan2014thru2020.pdf, p 7.

services … Specialized programs are provided to older adults, children and adolescents, and individuals with a forensic status."

Operating Capacity

The operating capacity for the eight adult behavioral health facilities is 1455 beds. The table below shows the operating capacity for the facilities on December 31, 2015.

FACILITY	OPERATIONAL BED CAPACITY
CAT	110
CSH	277
ESH	302*
NVMHI	134**
PGH	123
SVMHI	72
SWVMHI	179**
WSH	246
TOTAL	**1,443**

** This number includes 5 patient beds due to the 2014 closure of the Centers for Medicare and Medicaid- certified hospital unit in 2014 which remain unutilized and the reassignment of 4 patient beds in the facility's Community Preparation Program (CPP) to program rooms in 2013.*

*** NVMHI (13 beds) and SWVMHI (17 beds) expansion following implementation of the safety net law to allow for increased admissions.*

Data provided by DBHDS

TJC and CMS

All of the adult behavioral health facilities are accredited by The Joint Commission (TJC) under the Hospital Accreditation Standards. TJC is an independent, not-for-profit organization that administers voluntary accreditation programs for hospitals and other healthcare organizations, works to improve healthcare for the public and inspire healthcare organizations to provide safe, effective, and high quality care.

In order for the DBHDS-operated programs to participate in and receive payment from the Centers for Medicare and Medicaid Services (CMS) Medicare or Medicaid programs, they must remain in substantial compliance with quality and performance standards determined through regularly occurring inspections of CMS certified programs. Individuals admitted to these programs must also meet certain requirements in order for DBHDS to obtain proper payment through Medicare or Medicaid. TJC has been approved by CMS to administer acute admission and other surveys on their behalf through a deemed status survey. According to the Acting Director of DBHDS' Acute Care Services, there are 601 CMS-certified beds remaining in the adult behavioral health facilities:

DBHDS ADULT BEHAVIORAL HEALTH CMS-CERTIFIED BEDS		
FACILITY	***CERTIFIED BED TYPE***	***NUMBER***
CAT	Chronic Disease	60
CSH	----------	0
ESH	Acute Admissions	40
NVMHI	Acute Admissions	134
PGH	Chronic Disease	123
SVMHI	Acute Admissions	48
SWVMHI	Intermediate/Long-Term Care*	20
	Acute Admissions	92
WSH	Acute Admissions	84
TOTAL CMS-CERTIFIED BEDS		**601**
** SWVMHI has retained CMS-certified long-term care beds despite decertification at ESH and inability to certify beds at PGH and CAT.*		
Data provided by DBHDS		

Extraordinary Barriers to Discharge List

In addition to the increased admissions, two other variables influence patient flow and bed availability in the DBHDS-operated adult behavioral health facilities. The first, the extraordinary barriers list (EBL) is a list of individuals determined clinically ready for discharge who remain in the hospital for an additional 30 days due to difficulties facilitating discharge. In December of 2015 the criteria for inclusion in the EBL was changed to 14 days of clinical readiness. According to DBHDS' Assistant Commissioner of Behavioral Health Services, approximately 10-15 percent of the patients in the adult behavioral health facilities, at any given time, are ready for discharge and could be treated in a community setting if appropriate treatment alternatives were available.

- The DBHDS December 2015 EBL showed 160 individuals remained in facilities past the point of being clinically ready for discharge. Seventeen of these individuals (10.63 percent) had diagnoses that include intellectual or developmental disabilities. Extended hospital stays beyond the period of maximum benefit for persons determined ready for discharge may increase their risk for exacerbation of symptoms. Ten individuals (6 percent) on the December 2015 EBL were reported to have been removed from the list due to having deteriorated clinically while awaiting community placement.
- Geriatric individuals account for approximately 24 percent of those on the December 2015 EBL, indicating obstacles in the current system to treating adults age 65 and older who required treatment in a state facility in community settings.

Forensic Population

The second variable influencing patient flow and bed availability in the DBHDS-operated adult behavioral health facilities are the forensic (court-involved) individuals. Although frequently treated in separate programs, forensic TDO admissions have increased by 27 percent between FY 2014 (307) and FY 2015 (391). According to DBHDS forensic individuals currently occupy 38 percent of state behavioral health hospital beds. While DBHDS maintains that accommodating expanding forensic needs in the behavioral health facilities will continue to be problematic, necessitating the

reassignment of beds[2], OSIG contends that alternative options to fund and provide treatment for this population should still be considered in the future, and that assuming DBHDS-operated behavioral health facilities are the only option for treatment may be precipitous.

Hiram Davis Medical Center

HDMC is the only medical facility operated by DBHDS. The facility is located on the CSH campus in Petersburg. The facility is certified by CMS under a combination of skilled nursing facility (SNF) and nursing facility (NF) regulations. On January 12, 2015, HDMC requested a realignment of their 90 CMS-certified beds and an increase in the number of total certified beds. The change included a decrease in SNF beds from 63 to 50 and an increase in NF beds from 20 to 40 resulting in a total increase from 83 to 90 beds. Four general medical beds at the facility are not certified by CMS.

HDMC accepts patients for short-term hospital stays, referred to as "Special Hospitalization," and as permanent transfers from other DBHDS facilities. In addition to admissions from other DBHDS facilities, persons with intellectual and/or developmental disabilities (ID/DD) from the community are also accepted for admission to the medical center under Special Hospitalization status. According to information provided by the Facility Director, "The purpose of Special Hospitalization is to provide acute, immediate, short-term medical care. The length of the Special Hospitalization stay shall be directed by the medical needs of each individual. Emergency care, intensive care, respirator dependent care, and surgical care other than dental surgeries with general anesthesia are excluded from management at HDMC."

[2]Virginia Department of Behavioral Health and Developmental Services, Study of Piedmont and Catawba Geriatric Hospitals, http://leg2.state.va.us/dls/h&sdocs.nsf/fc86c2b17a1cf388852570f9006f1299/07a4790294b779e085257e430058cc53/$FILE/RD376.pdf, p. 4.

Review Methodology

This inspection was conducted in accordance with the Association of Inspectors General Principles and Standards for Offices of Inspector General Quality Standards for Inspections, Evaluations, and Reviews (May 2014). The work plan for the inspection was created after conducting an extensive literature search on the role of state hospitals, quality care, overcrowding, utilization, and staffing. Several DBHDS reports were also reviewed.

Inspections procedures included:

- Interview with the DBHDS Assistant Commissioner of Behavioral Health Services.
- Interviews with members of facility senior management and direct care staff, including:
    - Facility directors;
    - Admission coordinators;
    - Directors of Social Work;
    - Chief nurse executives; and
    - Sixty-seven staff members.
- Review of DBHDS data including:
    - DBHDS-operated behavioral health facility and HDMC admission and discharge data (FY 2013, FY 2014, and FY 2015);
    - DBHDS significant event data, including deaths, fractures, aggressive acts, falls, and intentional acts of self-injurious behavior (FY 2014 and FY 2015);
    - Seclusion and restraint data (FY 2014 and FY 2015);
    - Allegations of abuse and neglect data (FY 2013, FY 2014, and FY 2015);
    - Staff turnover rates (FY 2014 and FY 2015);
    - Number of individuals admitted to behavioral health facilities with intellectual and developmental disabilities; and
    - Staff overtime hours (FY 2014 and FY 2015).
- Documentation reviews and other activities:
    - 104 patient medical records;
    - Observations of 27 treatment team meetings; and
    - A review of policies and procedures related to, but not limited to, admissions and discharges.

Review Results

OSIG determined implementation of the safety net law has had a significant impact on the state-operated adult behavioral health facilities, HDMC, and the staff and individuals served. Adult and geriatric civil TDO admissions, discharges, utilization rates, and the rates of adverse events increased between FY 2014 and FY 2015. The inspections revealed a correlation between increased admission and utilization rates and adverse events. An even more noteworthy observation is that the significant impact of the safety net law on DBHDS-operated facilities, staff, and patients was neither fully planned for nor addressed in the subsequent eighteen months. While it is generally accepted that Virginia is in need of expanded community services to treat individuals with behavioral health issues, requiring additional funding and years of planning, DBHDS continues to operate eight behavioral health facilities and a medical facility that serve hundreds of individuals on any given day.

Objective: Impact of the Safety Net Law

CIVIL TDO ADMISSIONS

Individuals admitted to the facilities under a civil TDO are typically served on designated units that focus on assessment and stabilization with the aim of facilitating an individual's return to their home community with appropriate services and supports in place.

In FY 2014 and FY 2015, the DBHDS-operated behavioral health facilities experienced increases in TDO admissions for adults age 18-64 and those age 65 and older (geriatrics). It is noteworthy that the percentage growth in civil TDO admissions of individuals aged 65 and older was greater than that for adults aged 18-64. ESH, serving nine Community Services Boards (CSB) in the Tidewater region, experienced the greatest percentage increase of civil TDO admissions for both of these age groups between FY 2013 and FY 2015.

Although FY 2015 was the first full year the safety net law was in place, increases began early in 2014 at the time of the proposed changes. Since the implementation, admissions increased at all the facilities, except for SVMHI and SWVMHI. Both facilities experienced a decrease in the number of adult civil TDO admissions between FY 2014 and FY 2015, from 160 to 149 (a decrease of 7 percent) at SVMHI and from 585 to 535 (a decrease of 9 percent) at SWVMHI.

According to the November 2015 DBHDS Study of Piedmont Geriatric and Catawba Hospitals Report (Item 307.R),

> "State facilities have a greater role in crisis management and treatment after the passing of the "last resort legislation" in 2014. As a result, the need for state inpatient beds has increased and DBHDS is also requesting $22.3 million to add one more wing (56 beds) onto the new WSH. The facility infrastructure was designed and constructed to support an additional patient care unit…The construction of this addition is integral if a decision is made to close Catawba."[3]

[3] Ibid., p. 10.

The report does not include options for adding beds to ESH, which has experienced the greatest increase in bed demand.

The tables below show the number of adult and geriatric civil TDO admissions to the facilities from FY 2013 through FY 2015.

ADULT (AGE 18-64) CIVIL TDO ADMISSIONS FY 2013-FY 2015				
FACILITY	***FY 2013***	***FY 2014***	***FY 2015***	***% INCREASE FY 2013-FY 2015***
CAT	37	62	138	273
CSH	44	54	90	105
ESH	11	34	236	2,045
NVMHI	159	62	137	(14)
PGH	0	0	0	0
SVMHI	157	160	149	(5)
SWVMHI	512	585	535	4
WSH	25	56	145	480
TOTAL	**945**	**1,013**	**1,430**	**51%**
Data Provided by DBHDS				

GERIATRIC CIVIL TDO ADMISSIONS FY 2013-FY 2015				
FACILITY	***FY 2013***	***FY 2014***	***FY 2015***	***% INCREASE FY 2013-FY 2015***
CAT	22	40	83	277
CSH	0	0	0	0
ESH	3	5	56	1,767
NVMHI	0	0	0	0
PGH	5	15	57	1,040
SVMHI	0	0	0	0
SWVMHI	35	44	41	17
WSH	0	0	0	0
TOTAL	**65**	**104**	**237**	**265**
(FY 2013 used as baseline year due to increase in TDOs after November 2013)				
Data Provided by DBHDS				

There was a 127 percent increase in the number of geriatric civil TDO admissions between FY 2014 and FY 2015. Of the four facilities that accept geriatric patients, three experienced significant increases in geriatric civil TDO admissions. ESH experienced a 1,120 percent increase; PGH, a 280 percent increase; and CAT, a 108 percent increase. Only SWVMHI had a 7 percent decrease in geriatric civil TDO admissions.

DISCHARGES AND UTILIZATION

While there is variation among the facilities, the number of discharges from the adult behavioral health facilities since FY 2013 increased.

ADULT BEHAVIORAL HEALTH FACILITIES DISCHARGES: FY 2013-FY 2015			
FACILITY	***FY 2013 DISCHARGES***	***FY 2014 DISCHARGES***	***FY 2015 DISCHARGES***
CAT	249	240	344
CSH	534	494	606
ESH	256	300	604
NVMHI	692	543	832
PGH	53	66	114
SVMHI	270	307	283
SWVMHI	714	766	725
WSH	539	651	787
TOTAL	**3,307**	**3,367**	**4,295**
Data Provided by DBHDS			

According to data provided by DBHDS, hospital utilization rates have increased across the adult behavioral health facilities since FY 2013. The table below shows hospitalization utilization for FY 2013 through FY 2015.

ADULT BEHAVIORAL HEALTH FACILITIES UTILIZATION RATES: FY 2013-FY 2015									
	CAT	***CSH***	***ESH***	***NVMHI***	***PGH***	***SVMHI***	***SWVMHI***	***WSH***	***TOTAL AVERAGE***
FY 13	78%	75%	88%	96%	89%	79%	94%	90%	86%
FY 14	86%	66%	88%	97%	90%	93%	92%	86%	87%
FY 15	93%	79%	93%	93%*	95%	84%	89%*	94%	90%
** additional beds after safety net law*									
Data Provided by DBHDS									

Six of the eight adult behavioral health facilities experienced a utilization rate greater than 85 percent for FY 2015, the level at which facilities may experience greater "… quality of care considerations, adequacy of staffing, and increased risks to patient and staff safety …"[4]

INDIVIDUALS WITH SUBSTANCE USE DISORDERS

Facility medical directors and chief nurse executives reported to OSIG that adult behavioral health facilities are experiencing an increase in admissions of individuals with primary substance-use disorder diagnoses and with ID/DD since the safety net law went into effect. While the extent of the increase varies across facilities, those interviewed reported the need to treat these populations together raises multiple treatment and safety concerns, often requiring 1:1 monitoring, effectively decreasing the number of available staff on a unit. Data provided by DBHDS reflects that there was a 52 percent increase in admissions of individuals with a primary substance use disorder between FY 2014 (130 admissions) and FY 2015 (198 admissions). This did not include individuals with secondary substance use/dependence diagnoses who would also require assessment and treatment.

[4] Ibid. p. 3.

INTELLECTUALLY AND DEVELOPMENTALLY DISABLED INDIVIDUALS

Individuals with co-occurring ID/DD and behavioral health diagnoses are frequently treated in the same settings, whether a behavioral health program or one serving the specialized needs of the ID/DD individual. Only CAT experienced a decrease in the number of ID/DD admissions between FY 2013 and FY 2015, while PGH and SWVMHI experienced no change. The other facilities experienced significant increases, particularly ESH. The table below includes the number of ID/DD admissions by facility for FY 2013- FY 2015.

TOTAL ID/DD INDIVIDUALS ADMITTED				
FACILITY	***FY 2013***	***FY 2014***	***FY 2015***	***% INCREASE FY 2013-FY 2015***
CAT	16	7	14	(88)
CSH	37	51	43	116
ESH	6	11	62	1033
NVMHI	19	11	24	126
PGH	1	1	1	0
SVMHI	4	17	13	325
SWVMHI	2	0	2	0
WSH	26	21	42	162
TOTAL	**111**	**119**	**201**	**181**
Data provided by DBHDS				

OBSERVATION NO. 1: REVIEW FACILITY PROGRAMMING AND SCOPE OF SERVICES ACROSS THE SYSTEM

DBHDS adult behavioral health facilities have experienced significant changes following the implementation of the safety net law including:

- Increases in civil adult TDO admissions in all but SVMHI and SWVMHI,
- Increases in civil geriatric TDO admissions, in three of the four facilities serving geriatric patients,
- Increases in discharges in all but SVMHI and SWVMHI,
- Increases in bed utilization in all but SVMHI, SWVMHI, and NVMHI, and
- Increases in the number of ID/DD admissions in all but CAT, PGH, and SWVMHI ESH experienced the most significant increase (1033 percent).

Observation No. 1 Recommendation:

The DBHDS-operated behavioral health facility Chief Executive Officers, in partnership with the organized medical staffs, chief nurse executives, and DBHDS Central Office, review current facility programming and scope of services for each facility and across the system and revise them to address regional changes in admissions, discharges, and patient mix that have occurred since the implementation of the safety net law. Any changes requiring funding or approval of the General Assembly should be submitted accordingly.

STAFF MEASURES

The CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long-term Care Facilities (Rev. 149, 10-09-15)[5] under § 483.30 Nursing Services states,

> "The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care."

The CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 151, 11-20-15)[6] under §482.23(b) Standard: Staffing and Delivery of Care states,

> "The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient … A RN would not be considered immediately available if the RN were working on more than one unit, building, floor in a building, or provider (distinct part SNF, RHC, excluded unit, etc.) at the same time."

TJC 2015 Hospital Accreditation Standards[7] require hospitals to provide adequate numbers of RNs, LPNs, and mental health direct support professionals (DSPs) in order to provide the necessary care and documentation each patient requires. Changes in facility admission and discharge rates, patient mix, and utilization rates warrant updates to master staffing plans to ensure they reflect current hospital dynamics. Utilizing obsolete master staffing plans potentially creates accreditation and certification risks to facilities as well as risks to staff and patients.

In a 2011 Sentinel Event Alert, published by The Joint Commission[8], the connection between health care worker fatigue and adverse events is well documented and a warning to all health care facilities. Insufficient staffing, excessive workloads, shift length and work schedules all have direct connections to errors in patient care, close calls and "near misses".

In the adult behavioral health facilities, nursing department staff includes RNs, licensed practical nurses (LPNs), and DSPs. During the course of these inspections, OSIG reviewed two measures

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[5] CMS State Operations Manual Appendix PP - Guidance to Surveyors for Long-term Care Facilities (Rev. 149, 10-09-15), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf, p. 508.

[6] CMS State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 151, 11-20-15), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf, p. 214.

[7] The Joint Commission Hospital Accreditation Manual/E-dition, http://www.jointcommission.org/standards_information/edition.aspx.

[8] The Joint Commission Sentinel Event Alert Issue 48 Health care worker fatigue and patient safety, December 14, 2011, http://www.jointcommission.org/sea_issue_48/.

that have been shown to have an impact on staff and the quality of patient care: workload and turnover.

STAFF WORKLOAD

In the DBHDS adult behavioral health facilities, multiple variables impact the workload of nursing staff. These include patient acuity, patient comorbidities, and patient flow (admissions, discharges, and transfers). Although medical and nursing staff are most directly impacted by these factors, changes in any of them affect the operations of multiple departments including, but not limited to, Health Information Management [(HIM), formerly known as medical records], housekeeping, administrations, quality and risk management, and social work. These inspections showed there were a number of areas in which workload was impacted by the safety net law, increased admissions and discharges, and utilization rates. These areas include, but are not limited to the following:

1. *Code* § 37.2-809.1[A] requires CSB personnel to "contact the state facility for the area in which the community services board is located and notify the state facility that the individual will be transported to the facility upon issuance of a temporary detention order if no other facility of temporary detention can be identified by the time of the expiration of the period of emergency custody." In other words, the law requires that CSB personnel notify the state hospital of possible admissions whether the facility receives the person or not. CAT, ESH, SWVMHI, and WSH have added this function of communicating with the CSBs to nurse managers while the duty is shared across multiple positions in the other facilities. This function alone can add a considerable amount of work because it requires the individual to develop contingency plans for bed assignment and staffing patterns in the event the person is admitted.
2. In facilities without designated admission suites, such as CAT and ESH, registered nurses must leave their assigned units in order to complete admission assessments. RNs are the only nurses qualified by education and licensure that are able to assess patients limiting the ability to assign this responsibility another discipline. While the length of time away from their designated unit varies, registered nurses interviewed reported admissions can take between one and two hours to complete. For a unit with only one assigned registered nurse, this means that unit is without a RN for the period of time necessary to complete admissions. The potential absence of a RN during admission procedures, unless the units are staffed with more than one RN, would be out of compliance with CMS requirements.

STAFF TURNOVER

The turnover of direct care staff creates numerous risks to inpatient facilities, among them the cost of terminating staff, covering open shifts with overtime, use of mandatory overtime, costs of recruiting, hiring, and orienting new employees, etc. Nursing staff turnover rates in the DBHDS-operated adult behavioral health facilities increased 29 percent between FY 2014 and FY 2015. Although two of the facilities, CAT and SVMHI, experienced a decrease or minimal change in

turnover rates, the remaining six experienced increases. PGH and WSH had the most significant increases in turnover rates; PGH's rising from 17.2 percent to 30.7 percent and WSH's rising from 19.4 percent to 31.5 percent. (Appendix I)

OBSERVATION NO. 2: REVIEW MASTER STAFFING PLANS

Following the implementation of the safety net law, DBHDS-operated adult behavioral health facilities have experienced increases in staff workload and turnover.

> **Observation No. 2 Recommendation:**
>
> The Board of Nurse Executives should analyze current facility operations, patient mixes, acuity, work force demographics, revisions to the number of nursing hours per patient day, and required skills sets to determine if facility master staffing plans require revision in response to changes incurred following the implementation of the safety net law. Recommendations should be presented to DBHDS for consideration and utilized to request additional funding from the General Assembly to support any required staffing increases

PATIENT SAFETY MEASURES

The National Quality Forum (NQF), a not-for-profit, nonpartisan organization that works to catalyze improvements in healthcare, noted in the 2001 consensus statement Patient Safety: Call to Action[9]:

> "The NQF views safety as a fundamental and essential attribute of quality healthcare. Without safety there simply cannot be high quality. The NQF also considers improving patient safety as an ethical imperative for healthcare providers, individually and collectively, and error prevention and safety promotion to be the job of everyone who works in healthcare."

In its 2015 report, Free from Harm, Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human[10], the National Patient Safety Foundation defines patient safety as follows:

> "Patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events."

In a report at the 2015 WISH Patient Safety Forum, Transforming Patient Safety: A Sector-Wide Systems Approach Peter J. Pronovost, Senior Vice President for Patient Safety and Quality and Director of the Armstrong Institute for Patient Safety and Quality at John Hopkins Hospital, stated that advancing patient safety requires a shift from reactive, segmented interventions to a total systems approach. The report goes on to say that a total systems approach would mean the constant

[9] Patient safety: a call to action: a consensus statement from the National Quality Forum, http://www.ncbi.nlm.nih.gov/pubmed/11549959, p. 5.

[10] National Patient Safety Foundation, Free from Harm, Accelerating Patient Safety Improvement Fifteen Years after To Err is Human, http://www.npsf.org/?page=freefromharm, p. xii.

prioritization of safety culture by leadership and that, "Perturbing one element of the system without considering its impact on the other elements of the system may result in a breakdown."[11]

During the FY 2015 inspections, OSIG reviewed patient safety measures, such as deaths, serious injuries, falls, fractures, and self-injurious behaviors to determine the impact of the safety net law on patient safety. These measures were chosen based upon the availability of consistent data from DBHDS. To determine the level of attention DBHDS had placed on the impact of the safety net law on patient safety measures, OSIG interviewed a member of the DBHDS executive team and was informed that DBHDS has not conducted a formal systemic review of adverse events from the various databases maintained by DBHDS since the safety net law went into effect.

DEATHS AND SERIOUS INJURIES

The number of deaths reported through the DBHDS Protection and Advocacy Incident Reporting System (PAIRS) event database in the adult behavioral health facilities increased by 85 percent between FY 2014 and FY 2015. There was also an increase in the number of serious events requiring physician or physician-extender intervention, except in the category of aggressive acts. An event considered reportable in PAIRS is one that requires physician or physician extender intervention. Near misses, any process variation that did not affect an outcome but for which a recurrence carries a significant change of a serious adverse outcome, are not captured by this or any other DBHDS database. While there are limitations in terms of the usefulness of PAIRS data at the current time, it is the tool utilized by DBHDS-operated facilities to report significant events.

ADULT BEHAVIORAL HEALTH FACILITY EVENTS REPORTED IN PAIRS: FY 2014 & FY 2015

INCIDENT TYPE	*FY 2014*	*FY 2015*	*INCREASE*
Deaths	27	50	85%
Falls	59	77	31%
Fractures	45	61	36%
Self-Injurious Behaviors (Intentional)	23	38	65%

Data provided by DBHDS

OBSERVATION NO. 3: ASSESS THE IMPACT ON FACILITY PATIENT SAFETY

Following the implementation of the safety net law, DBHDS-operated adult behavioral health facilities experienced an increase in patient safety adverse events. The impact of changes following the implementation of the safety net law on patient safety for individuals served in facilities has not been fully analyzed to identify trends, patterns, or root causes to support systemic patient safety initiatives.

Observation No. 3 Recommendation:

[11] Report of the WISH Patient Safety Forum 2015, Transforming Patient Safety, A Sector-Wide Systems Approach, http://dpnfts5nbrdps.cloudfront.net/app/media/1430, p. 14.

DBHDS develop a plan to assess the impact of facility changes following implementation of the safety net law on patient safety in the adult behavioral health facilities. The results of that assessment should be utilized to develop system-wide patient safety initiatives.

HIRAM DAVIS MEDICAL CENTER ADMISSIONS

Admissions to HDMC from the DBHDS-operated adult behavioral health facilities increased by 141 percent between FY 2014 and FY 2015. HDMC leadership reported that this increase was directly related to the increased demand of state psychiatric bed availability under the safety net law, although data to support this was beyond the scope of these inspections.

In FY 2014, the greatest percentage of transfers/admissions from state-operated adult behavioral health facilities to HDMC were from CSH and PGH (25 percent) and in FY 2015 CAT and PGH (68 percent).

TRANSFERS/ADMISSIONS TO HDMC						
BH FACILITY OF ORIGIN	*PERMANENT TRANSFER/ ADMISSION*		*SPECIAL HOSPITALIZATION*		*SUBTOTOTALS*	
	FY 2014	*FY 2015*	*FY 2014*	*FY 2015*	*FY 2014*	*FY 2015*
CSH-Civil	3	5	4	6	7	11
CSH-Forensic	0	0	0	0	0	0
VCBR	0	0	0	1	0	1
ESH	0	0	0	1	0	1
PGH	3	15	5	6	8	21
SWVMHI	1	1	1	1	2	2
NVMHI	2	0	0	0	2	0
CAT	2	10	0	1	2	11
WSH	0	6	0	0	0	6
Direct	1	0	0	0	1	0
TOTALS	**12**	**37**	**10**	**16**	**22**	**53**
Data provided by DBHDS						

Adult behavioral health facility temporary or permanent transfers to HDMC must meet the following requirements:

- The individual requires SNF or NF level of care, and
- The individual's mental health and/or behavioral symptoms are stabilized.

According to information provided by the Facility Director,

> "The interdisciplinary team (IDT) of the referring behavioral health facility and the proposed receiving HDMC IDT must have a conference call to assess appropriateness prior to transfer. When there are questions about the suitability of the transfer, members of the HDMC IDT will travel to the referring facility to review and assess the patient's condition."

The Facility Director also reported that in order to ensure HDMC maintains its Long-term Care certification, the final decision to accept a transfer admission from the behavioral health facilities

rests with the HDMC Medical Director with feedback from the IDT. The Medical Director determines admission is based on medical necessity through a review of the patient's medical history, current medical diagnosis, and treatment objectives.

The HDMC Facility Director reported working closely with the HDMC Medical Director and DBHDS Central Office staff on managing admissions. Careful monitoring of admissions from the state-operated behavioral health facilities occurs to make sure that the mental health population does not exceed fifty percent of the total population. If the majority of patients served have a primary behavioral health diagnosis, HDMC runs the risk of being classified as an institution of mental disease (IMD), potentially placing the medical center's CMS certification at risk. An IMD, under Medicaid regulations, is defined as a hospital, nursing facility or other institution of more than 16 beds that "primarily engages in providing diagnosis and care for persons with mental illness, including medical attention, nursing care, and other related services." [12]

The Director of Social Work at HDMC communicated that since transfers from the behavioral health facilities are not based on patient choice but medical necessity, one of the disadvantages for some patients and their authorized representatives is the distance from their home community and significant others.

[12] Code of Federal Regulations, Title 42 Public Health, Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, https://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-chapIV.pdf, p. 57.

OBSERVATION NO. 4: EXPLORE CURRENT AND FUTURE ROLE OF HDMC AND OTHER FACILITIES FOR PATIENTS REQUIRING SPECIALIZED CARE.

Following the implementation of the safety net law there has been a significant increase in the number of transfers to HDMC from the state-operated behavioral health facilities, particularly PGH and CAT.

Observation No. 4 Recommendation:

DBHDS explore the current and future role of HDMC and other DBHDS-operated facilities in serving adult behavioral health facility patients requiring medical, skilled nursing, and nursing facility level care. Once determined, DBHDS and the General Assembly should determine the future role of DBHDS, HDMC, and other facilities in providing this level of care.

MANAGEMENT RESPONSE

DBHDS concurs with the recommendations contained within the report.

Appendix I — Direct Care Staff Turnover Rates

DBHDS ADULT BEHAVIORAL HEALTH FACILITIES DIRECT CARE STAFF: AVERAGE POSITIONS FILLED, NUMBER OF SEPARATIONS, & TURNOVER PERCENTAGES FY 2014-FY 2015			
	FY 2014	***FY 2015***	
CAT	112	114.5	Average Positions Filled
	48	44	Total Separations
	42.9%	38.4%	Percentage Turnover
CSH	538.5	519	Average Positions Filled
	126	136	Total Separations
	23.4%	26.2%	Percentage Turnover
ESH	475	463	Average Positions Filled
	103	134	Total Separations
	21.7%	28.9%	Percentage Turnover
NVMHI	161.5	162.5	Average Positions Filled
	32	47	Total Separations
	19.8%	28.9%	Percentage Turnover
PGH	174	176	Average Positions Filled
	30	54	Total Separations
	17.2%	30.7%	Percentage Turnover
SVMHI	86	95.5	Average Positions Filled
	22	24	Total Separations
	25.6%	25.1%	Percentage Turnover
SWVMHI	279	285	Average Positions Filled
	38	54	Total Separations
	13.6%	18.9%	Percentage Turnover
WSH	345.5	337	Average Positions Filled
	67	106	Total Separations
	19.4%	31.5%	Percentage Turnover
ALL FACILITIES	**2,171.5**	**2,152.5**	Average Positions Filled
	466	**599**	Total Separations
	21.4%	**27.8%**	Percentage Turnover