disABILITY LAW CENTER
OF VIRGINIA

Protection & Advocacy for Virginians with Disabilities

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Dr. Hughes Melton
Commissioner
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, Virginia 23219

Dear Commissioner Melton,

On behalf of the disAbility Law Center of Virginia, we congratulate you on your appointment as Commissioner of the Department of Behavioral Health and Developmental Services. As you may know, dLCV is the designated protection and advocacy organization for the Commonwealth of Virginia. Among our many responsibilities, we routinely monitor DBHDS-operated institutions. We regularly collect and analyze data from DBHDS.

We recently completed an analysis of critical incidents, as reported through the PAIRS system, which raised concerns that we would like to bring to your attention. I am including a draft report with our analysis of incidents in state operated mental health facilities. Of special note, in federal FY 17, DBHDS reported the most mental health facility deaths since 2012. On closer review, we identified a possible pattern of concern. Individuals dying within 3 months of being admitted to a state mental health facility make up more than 30 percent of total deaths.

We speculate that the changes enacted by the legislature in 2014 to Virginia Code § 37.2-809, specifically making state hospitals the facilities of last resort, may be contributing to this pattern. The effect of the "last resort" law appears to be not only more people being admitted to state facilities, but people with more complex medical needs being admitted. Some facility directors have shared their concern that they must admit individuals with medical needs that they are ill-equipped to address in a stand-alone psychiatric hospital. Likewise, we note that the proportion of critical incidents resulting from "medical conditions" also increased substantially between FY16 and FY17, suggesting a population with increasingly significant medical needs.

An increased number of geriatric patients in state hospitals may also contribute to this spike in deaths. The rate of deaths was most pronounced at two facilities that accept geriatric patients, Catawba (CAT) and Piedmont Geriatric Hospital (PGH). However, although CAT and PGH reported disproportionately high rates of patient deaths, other facilities serving geriatric residents reported relatively low rates of death. Therefore it seems that geriatric population, of itself, cannot account for the increase in reported deaths.

What the data can tell us is that conditions preceding death at DBHDS-operated facilities have historically been (and remain) primarily "Medical Condition." Medical Conditions made up 51 of the 57 deaths, underscoring the difficulty in managing chronic medical conditions in psychiatric facilities. However, incomplete reporting and a lack of data on the underlying medical conditions themselves make it difficult for us to explore this connection. As we do not have admissions data for all relevant periods of time, our analysis of the increase in number of deaths is necessarily incomplete. More detailed data analysis could allow DBHDS to address contributing factors, which may include staffing levels, quality of care, or simply a higher total number of admissions.

We have an additional concern with the reporting of critical incidents from state mental health facilities. In FY17, mental health facilities operated by the DBHDS reported the highest number of serious injuries in the last five (5) years. Despite this apparent increase in reportable incidents, dLCV is aware of qualifying incidents at multiple state hospitals that have gone unreported to dLCV. Our on-site monitoring reveals confusion and inconsistencies as result of the Department's policy on critical incident reporting. We believe the Department's policy unnecessarily constrains the interpretation of reporting obligations found in Virginia Code § 37.2-709 and § 37.2-709.1.

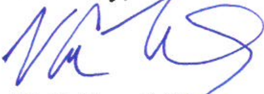
A recent report by the Office of the State Inspector General (OSIG) examined DBHDS' reporting practices at facilities and concluded:

> *As a leading cause and concern, OSIG found the current DBHDS event reporting and response system ... to be inadequate and in need of a comprehensive revision. DI401, last revised in 2012, is an outdated policy that contains areas of ambiguity and lacks definitions for key terms and criteria or specific requirements for key processes. The lack of clearly defined criteria and guidelines limits facilities' ability to take advantage of opportunities for quality reporting, analysis and performance improvement. Application of DI401 ... has the potential to, and in some cases does, cause a variety of harmful errors, inefficiencies, waste and redundancies.*

dLCV agrees with these findings and the OSIG's proposed recommendations, including revision and review of DI401.

We look forward to working with you and the Department to improve the quality of services and safety for individuals served in DBHDS operated facilities, and share the Department's desire for better resourced community based services to relieve pressure on the state facilities. We anticipate making our review of the incident reports available to the public within 30 days. If you have additional information that would inform our conclusions, we welcome it and will incorporate it into our report as appropriate.

Sincerely,



V. Colleen Miller
Executive Director

Cc: Daniel Herr, Deputy Commissioner