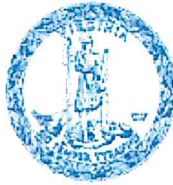

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September 18, 2018

V. Colleen Miller, Executive Director
Disability Law Center of Virginia
1512 Willow Lawn Drive, Suite 100
Richmond, VA 23230

Dear Ms. Miller;

Thank you for your letter of June 18, 2018 and the attendant report, *Report on Critical Incidents in Virginia's State Operated Mental Health Facilities: October 1, 2016 – September 30, 2017.*

We have reviewed the report and the data upon which it was based and compared it to our internal data as it relates to serious events, including deaths that are reported to dLCV. While we noted a number of differences between the DBHDS internal data and the data in the dLCV report, we agree that concerns regarding serious injuries and deaths are important and warrant continued review. These discrepancies may be due to the source of the dLCV data, which appears to be the PAIRS reporting system. The PAIRS was established primarily as an information reporting system to comply with the *Code of Virginia § 37.2-709. State facility reporting requirements,* and not as a data system. Thus, the non-text fields in PAIRS were established to meet *descriptive* reporting requirement and not to serve as a repository of reliable *quantitative* data.

There were some statements made in the report, with which we think that further context is important. For example:

- The report states that "facilities did not provide details on the deaths attributed to medical conditions in spite of the statutory requirement to provide all known details in the 15 day report." We would like to point out that in many cases all of the details are not known, or compiled within 15 days of a death, particularly more complicated medical cases. DBHDS facilities complete a mortality review of all unexpected deaths within 45 days, which allows time to gather all of the relevant information.
- The report also states that the data on Discharge Prior to Death "revealed some disturbing patterns,' presumably that individuals are frequently discharged to hospice providers, hospitals and other settings prior to death. The report later notes concern

with an increase in the proportion of deaths that occur within 90 days of admission. While we believe that the discharge of individuals to other facilities to address medical needs was appropriate, we share your concern with the medical acuity of many of the patients admitted to DBHDS facilities since implementation of Virginia Code § 37.2-809.

- Finally, the report addresses concerns with the consistency of reporting and references similar concerns raised by the Office of the State Inspector General (OSIG). DBHDS has already begun addressing the OSIG recommendations, revising DI401 and improving the platform for reporting serious incidents and deaths.

While the DBHDS does not agree with all of the statements, calculations or conclusions of the report, we believe the areas of concern – serious injuries and deaths – are of sufficient importance that they warrant a closer internal examination. The report has additionally highlighted the need to more clearly define the non-text fields in the PAIRS system to allow for more reliable data and greater accuracy in the interpretation of the data derived from this system.

As noted above, in May, 2018, the DBHDS established a project team to evaluate and update the state facility risk management system to include new and updated structures and processes for ensuring more consistent reporting of serious events; to establish requirements for intensive reviews of events, including mortality reviews and root cause analyses; to address proactive risk reduction strategies; and to more clearly define the requirements for ongoing monitoring of and response to serious events and trends. As part of this project the DBHDS will establish data definitions and guidance for event reporting to improve the quality of all risk-related data. The project team will be provided a copy of the dLCV report to consider how best to address the concerns and recommendations provided therein.

The DBHDS is developing plans to establish a central office mortality review committee to review deaths in state hospitals. This is another initiative that will address the concerns noted in the report.

If you have any questions, or if you or a staff member wish to further discuss the report, please feel free to contact Daniel Herr, Deputy Commissioner Behavioral Health by phone at 804-786-7287 or by email at daniel.herr@dbhds.virginia.gov or Dev Nair, Assistant Commissioner, Quality Assurance and Regulatory Compliance by phone at 804-225-3857, or by email at dev.nair@dbhds.virginia.gov .

Sincerely,

S. Hughes Melton, M.D., M.B.A
Commissioner

Daniel Herr, JD, Deputy Commissioner
Dev Nair, Ph.D., Assistant Commissioner