COMMONWEALTH of VIRGINIA

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April 24, 2019

V. Colleen Miller, Executive Director
disAbility Law Center of Virginia
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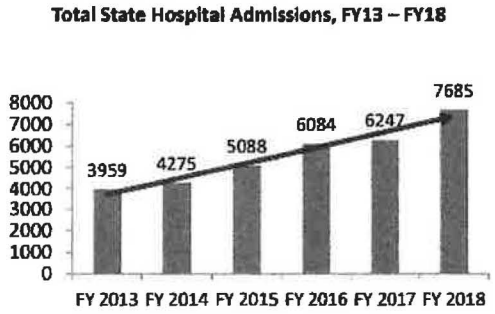
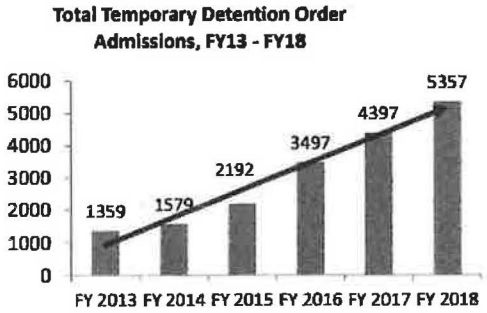
Dear Ms. Miller:

Thank you for your letter of April 3, 2019 and the attendant report, *Report on Critical Incidents in Virginia's Mental Health Facilities October 1, 2017 – September 30, 2018.*

I have reviewed the report and the data on which the report was based. The Department of Behavioral Health and Developmental Services (DBHDS) is committed to providing quality care and safety for the increasing numbers of high risk individuals served by the state hospitals who have both behavioral health needs as well as complex and comorbid medical conditions. As your report suggests, following the adoption of the "last resort" legislation on July 1, 2014, DBHDS state hospitals experience a 294% increase in civil temporary detention order (TDO) admissions, and a 94% increase in total admissions. Please see the chart below.





The statewide statistic above obscures the disparate impact of the "last resort" legislation on those hospitals that historically provided primarily longer-term care for individuals who were transferred from private hospitals to that state hospital for extended care. As you will note in the chart below, the percentage of increase in civil TDO admissions ranged from a low of 26% at Southwestern Virginia Mental Health Institute to a high of 3,723% at Eastern State Hospital.

Comparison of Civil TDO to Total Admissions FY 13 and FY 18						
Facility	FY 13 Civil TDO	FY 13 Total Admit	FY 18 Civil TDO	FY 18 Total Admit	% Civil TDO Increase	% Total Admit Increase
Catawba	59	249	497	620	742.4	149.0
Central State	44	514	605	1041	1275.0	102.5
CCCA	350	691	885	983	152.9	42.3
ESH	13	242	497	1015	3723.1	319.4
NVMHI	159	693	1123	1341	606.3	93.5
PGH	5	59	120	156	2300.0	164.4
SVMHI	157	261	301	425	91.7	62.8
SWVMHI	547	720	689	906	26.0	25.8
WSH	25	530	640	1198	2460.0	126.0

* data taken from Enterprise Data reporting warehouse
* reporting periods 7/1/2012-6/30/2013 and 7/1/2017-6/30/2018

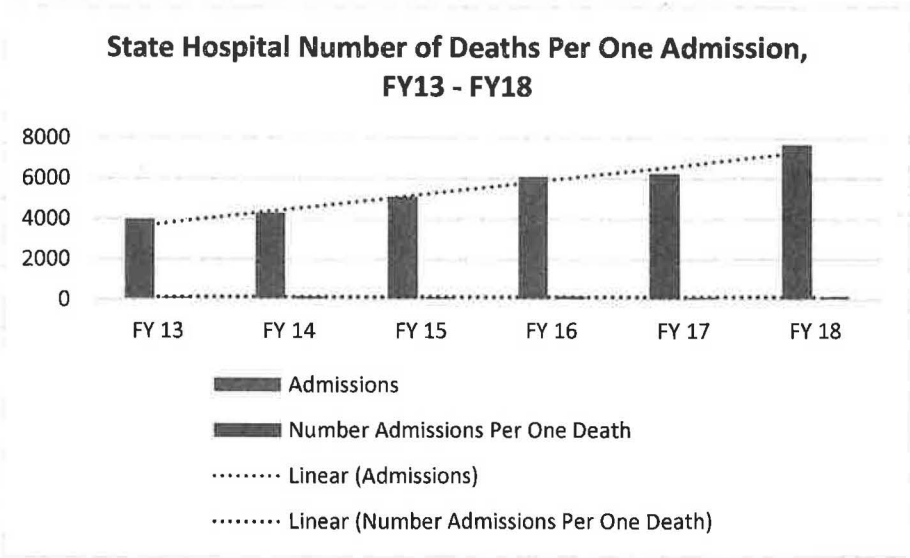
Additionally, as you know, individuals with serious and persistent mental illness have a reduced life expectancy of as much as 25 or more years when compared to the general population.[1] As your report suggests, along with the dramatic increase in admissions, DBHDS state hospitals are providing care for a growing number of individuals with complex medical conditions, including those with known life threatening conditions, as well as those who are terminally ill. Since the adoption of the last resort legislation, the cost of medical care for individuals in state hospitals has doubled, growing from $3.5 million in FY 2013 to $7 million in FY 2018.

Individual living with serious mental illness, who are admitted directly from the community, constitute the population with the highest level of risk for undetected, untreated, or under-treated medical conditions. DBHDS reviews the deaths that occur in state hospitals from multiple perspectives. First, given the 294% increase in admission, and the growth in the state hospital census, DBHDS considers the base rate in deaths per admission. Although the base rates in death by admission have fluctuated from year to year, the data does not indicate an overall increase in deaths. Please see the state hospital base rates per admission below.

- FY 13 = 1 death per 107 admissions
- FY 14 = 1 death per 147 admissions
- FY 15 = 1 death per 96 admissions
- FY 16 = 1 death per 164 admissions
- FY 17 = 1 death per 104 admissions
- FY 18 = 1 death per 134 admissions

The chart below shows the deaths per admission and the total state hospital admissions.

[1] https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3915-research-weekly-mortality-gap-for-serious-mental-illness-widens- ; https://www.nami.org/learn-more/mental-health-by-the-numbers; https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml



Secondly, DBHDS compares the deaths in state hospitals based upon the literature and research that is as closely normed as possible to the population it serves, i.e., individuals with serious behavioral health needs who are much less likely than the general population to have received adequate primary and specialty care. (The seven triggers you sited in your April 3rd letter were developed for a population with developmental and physical disabilities and were not adapted nor intended to be used for the population served in our nine mental health hospitals.) Thus, for any population who does not receive basic health care, the cause of death is almost always multi-causal and rarely limited to one specific medical condition.

DBHDS' FY 18 data shows that 57 individuals died in state hospitals or within 21 days of discharge. Of note, our data indicates there were 57 deaths in FY 18 and your data shows 59; this could be because of differing collection periods or some other methodology. Of those 57 individuals in DBHDS' FY 18 data, 33 (or 58%) were admitted to a state hospital with an identified life threatening medical condition or a terminal illness. Due to the limited life expectancy for these 33 individuals, either the individual or their legal decision maker had issued "do not resuscitate" instructions for the medical staff that stated that no heroic life saving measure could be taken. For the majority of the individuals with life threatening conditions, or who required palliative care, and who had DNRs, the attribution of a sole cause of death obscures the complexity of their multiple medical conditions that ultimately contributed to their death.

In addition, 24 (or 42%) of these individuals died after discharge in a medical hospital or palliative care setting after discharge. A report by an independent contractor who analyzed Virginia gero-psychiatric services spoke to these end of life issues. Of the 57 individuals, 49 (or 86%), were over age 65. These independent experts recognized and addressed the end of life care that the state hospitals are now providing as a result of last resort legislation.[2] Below you will also find a chart comparing the cause of death for individuals in state hospitals with the cause of death for Virginians statewide.

[2] https://rga.lis.virginia.gov/Published/2017/RD513/PDF.

	Statewide Deaths		State Hospital Deaths	
	Number	*Percent*	*Number*	*Percent*
Heart disease and related ICD codes	16889	29%	17	30%
Cancer	12972	22%	3	5%
All other Diseases (residual of D65-N98)	8061	14%	3	5%
Unintentional Injuries	3346	6%	1	2%
Cerebrovascular Accidents	3014	5%		
Chronic Lower Respiratory Infections	2870	5%	11	19%
Alzheimer's	2207	4%	5	9%
Diabetes	1719	3%	1	2%
Kidney disease	1380	2%	5	9%
Suicide (Intentional Self Harm)	1045	2%		
Influenza and Pneumonia	1006	2%	11	19%
Unknown pending medical examiner report				
Total deaths	**58559**		**57**	

In addition to DBHDS' review of deaths, I wanted to simply take note of the fact that all of DBHDS' hospitals are accredited by the Joint Commission. The Joint Commission considers unexpected deaths to be a sentinel event and reviews such events at the time they survey a hospital. The Joint Commission has not issued any findings nor required any corrective action plans for the hospitals review or action plans following a death since 2013.

In conclusion, I did wish to make sure you are aware that SB1488 passed by the 2019 General Assembly requires the Secretary of Health and Human Resources to convene a work group to review and make recommendations on the "last resort" legislation and to specifically address the "treatment needs of individuals with complex medical conditions."

Sincerely,

S. Hughes Melton, MD, MBA

c: Heidi Dix, Deputy Commissioner for Compliance, Legislative, and Regulatory Affairs
Daniel Herr, Deputy Commissioner for Facility Services