COMMONWEALTH of VIRGINIA

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COMMISSIONER

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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 giving us the opportunity to respond to dLCV's report entitled, *Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2018 – September 30, 2019.* We are pleased to report several updates that address many of the report's findings and recommendations from the federal fiscal year that ended nearly 12 months ago.

The report notes many general concerns with the overall quality and timeliness of serious incident reports and follow up reports produced by DBHDS facilities. DBHDS has taken many steps in the last 18 months to address incident reporting across its facilities; largely in response to previous dLCV reports as well as recommendations in a November 2019 report from the Office of the State Inspector General (OSIG).

1. In April 2020, DBHDS released a new event tracker system and new Form 158 to improve consistency in what is reported and when it is reported. As of this September 21st, all DBHDS facilities are using the event tracker system to report incidents. Reporting is monitored daily for timeliness.

2. In the spring of 2020, DBHDS began tracking and analyzing trends related deaths and serious incidents. Both deaths and serious incidents are now reviewed monthly as part of Key Performance Indicator (KPI) reviews.

3. On August 28, 2020, DBHDS issued an updated Departmental Instruction (DI) 315 regarding reporting reviews and deaths. The updated DI includes new Central Office requirements to review case information sent by facilities, analysis of this data on a quarterly basis, facilitation of the statewide Mortality Review Committee (MRC) and focus on systemic quality improvement in DBHDS facilities.

4. On September 4, 2020, DBHDS issued an updated DI 401. The update includes quality control measures, such as a look behind review of a sample of incidents each year to ensure quality and

consistency in reporting. As part of this relatively new update, DBHDS will remind facilities that follow-up reports are due within 15 *working days* of an incident.[1]

5. DBHDS has also formed a workgroup to streamline and consolidate the internal and external incident and complaint documentation standards and reporting processes for its facilities. The workgroup is examining ways to consistently respond to dLCV inquiries and complaints.

Your report also states that dLCV remains concerned about the continued high number of medically complex and terminally ill consumers being served in state mental health institutions, rather than in appropriate medical facilities. We agree that it has been challenging to address the many co-occurring medical conditions of individuals civilly committed to state hospitals. DBHDS has worked to the best of its ability with private hospitals and CSBs to ensure that individuals who have medical conditions in need of treatment are not admitted to DBHDS state hospitals and/or receive appropriate care via special hospitalization. If we cannot meet the standard of care required for the individual, we locate an appropriate placement as soon as feasible or add clinical consultation or equipment to address the needs.

We do not consider the care we provide in our state hospitals, when no other treatment options are available, neglect. In addition, as you are aware, the 2020 General Assembly clarified the existing medical TDO statute in order to assist individuals and treatment providers in ensuring individuals received medical treatment before admission to a state hospital.

We have a few technical concerns with the report. First, as we have noted in previous responses to reports, the "7 Medical Triggers" used on page 11 of this report are factors related to the morbidity and mortality of the developmental disability population. Premature death in individuals with serious mental illness are due to chronic physical medical conditions, similar to the general population, however with a 10-25 year life expectancy reduction, due to medical conditions being under recognized or under treated due to a multitude of psychosocial factors (World Health Organization).

Second, dLCV defines "palliative care" in its discussions as DDNR, Do Not Resuscitate, Palliative Care, Comfort Care, Comfort Measures, or Hospice Care. While these terms overlap, they are distinct in their role in the treatment of an individual with a serious medical condition or at end-of-life. DDNR and DNR allows qualified healthcare professionals to honor a person's request for humane comfort measures while avoiding resuscitation, in the event of a cardiac arrest. Any person may request a DNR or DDNR, regardless of his/her health status. This is not the same as palliative care or hospice care. Palliative care describes the comprehensive and holistic care a person with a serious illness receives for as long as necessary with the hopes of potential cure or life-saving treatment. Hospice is similar to palliative care, with the exception that curative treatment is not anticipated. (National Institute on Aging). In the context of the findings of your report, this is an important distinction that should be considered.

Thank you for permitting us to review and respond to the report in advance. If you would like to discuss our response in more detail, please contact Angela Harvell, Deputy Commissioner for Facility Services at 804-225-3829.

Sincerely,

Alison G. Land, FACHE
Commissioner

[1] In addition to 15 day follow up reports, per DI 315 facilities have 45 days to complete a mortality review.