COMMONWEALTH of VIRGINIA

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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, 2019 – September 30, 2020*. We appreciate the recognition of the work our team and staff have done during the COVID-19 pandemic to prevent infection among staff and patients and to maintain safe staffing in such a challenging environment.

The report notes many general concerns with the overall quality and timeliness of serious incident reports and follow up reports produced by DBHDS facilities. As we noted in our response to last year's report, DBHDS took many steps during calendar year 2020 to address incident reporting across facilities; many of these changes did not occur until well in the period of dLCV's review.

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 21, 2020 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 to 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.

We continue to move forward with implementation of the new DI's, KPI reviews, and event tracking. The data and information from the event tracker and the KPI reviews are critical in addressing quality and care concerns in our facilities. The results of the look behind reviews and the MRC have just begun. We anticipate using these processes to drive systemic quality improvement.
dLCV's analysis indicates a high number of deaths at Piedmont Geriatric Hospital (PGH), with the majority of deaths not associated with COVID-19. PGH, as a geriatric hospital, has a more vulnerable population with complex medical issues. We agree that it has been challenging to address the many co-occurring medical conditions of individuals civilly committed to PGH. 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 when feasible and/or receive appropriate care via special hospitalization. PGH also works to refer patients to specialists as determined appropriate by their treatment team. DBHDS is working to improve compensation for our direct care staff (i.e. DSAs, LPNs, RNs) in order to improve recruitment and retention of the staff most critical to ensure our patients' safety.

It is important to note that DBHDS has taken proactive steps this year to work with the Northam Administration and the General Assembly to provide alternatives for individuals with a primary diagnosis of dementia. These individuals should not be civilly committed and require services in a nursing home, assisted living, or memory care setting. These alternatives are more appropriate for many of the patients at PGH with co-occurring medical conditions. Actions to create alternatives for this population along with efforts to improve staff compensation, if successful, will have a statewide impact on our system and patient care.

One example we are hoping to duplicate is a partnership with Mt. Rogers CSB and Valley Health in southwest Virginia. This is a program to assist with individuals discharged from our state facilities to Valley Health's specialized unit where we have contracted with Mt. Rogers to place two social workers to supply activity therapies, develop individualized crisis plans and build competence of the nursing facility staff to manage these individuals successfully in the community. We also advocated for and received funding in the 2021 General Assembly session to contract with a nursing home provider to offer care specific to our geriatric behavioral health population, so we are better able to address their needs. We look forward to working with you and other stakeholders to identify additional opportunities to improve support for the geriatric population.

Your report also addressed several concerns with reporting at Eastern State Hospital (ESH). As noted above, recent actions to improve reporting and Central Office oversight of reporting such as KPI reviews and DI's are still relatively new and developing. In addition, we have learned since reviewing your draft that ESH enters incidents into PAIRS if medical treatment required or hospital visit. For example, a fall would not be entered unless there is an injury requiring treatment or hospitalization. We will clarify expectations for entering serious incidents into PAIRS for all state facilities and monitor reporting consistency.

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 16 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

c: Angela Harvell