COMMONWEALTH of VIRGINIA

NELSON SMITH
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

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

Dear Ms. Miller:

DBHDS has reviewed the dLCV's report entitled, *Report on Critical Incidents in Virginia's State Operated Mental Health Facilities October 1, 2021 – September 30, 2022*. For the time period in question, the Commonwealth's state facilities continued to recover from the impact of the COVID-19 pandemic, critical staffing shortages, and increased acuity and safety concerns. Quality service delivery remains our highest priority as evidenced by the efforts outlined below. As reported in previous years, DBHDS has made strives to improve the quality and timeliness of critical incident reports.

Namely, DBHDS has reestablished the Facility Services Division to support the operation of state facilities as one healthcare system to implement best practices, identify efficiencies, and ensure quality support delivery. This effort will support improved reporting and shared efforts to reduce critical events across the system, to name a few.

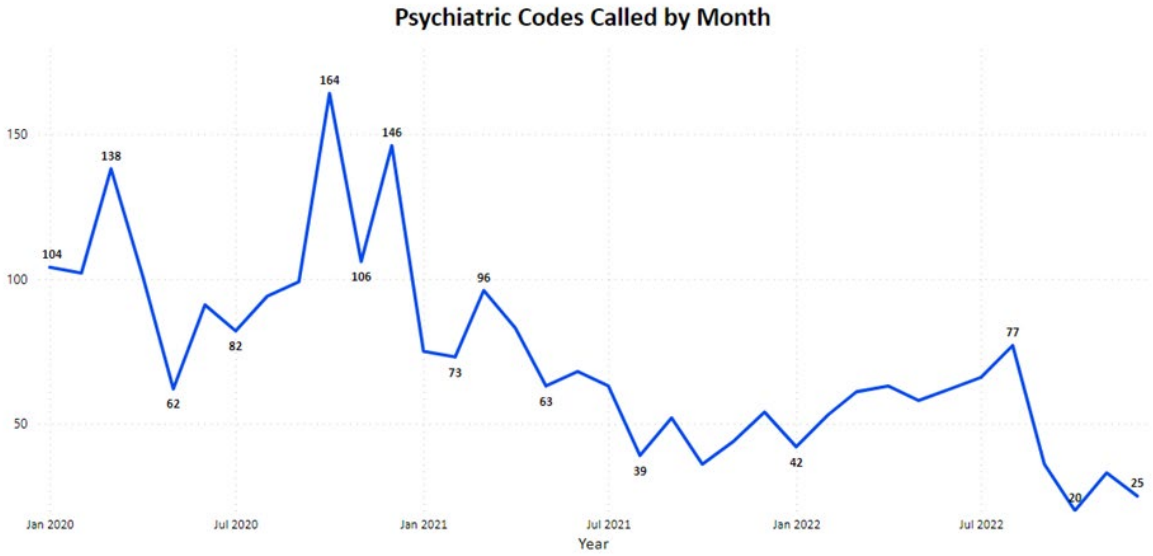
As acknowledged in this year's dLCV report, the number of deaths decreased dramatically from FY 2021 to FY 2022 which can be attributed to the impact of COVID-19 regarding geriatric deaths across the state system. However, there were a number of concerns outlined, including the 1) rise in reporting of self-injurious behavior and alleged peer to peer sexual assault, 2) quality and quantity of reported critical incidents, and 3) adequate reporting to dLCV. DBHDS offers the following clarifications:

Incident Types and Reporting:

1. Decrease in medical condition reporting at CSH and ESH: Prior to July 2021, CSH and WSH reported all private hospital emergency department (ED) visits in PAIRS even if there was no "event." These hospitals have since stopped reporting ED visits and/or hospitalizations that are solely the result of medical conditions. This change makes CSH and ESH ED and

hospitalization reporting consistent with other facilities' reporting of medical incidents as critical events.

2. Decrease in critical incident reports (CIR) at ESH: In FY 2021, ESH reported 45 serious critical incidents and 28 in FY 2022. The difference in percentage decrease between FY 2021 and FY 2022 is approximately 0.5 percent of annual critical incident submissions, comparatively. There are also significant differences in how ESH was operated between those two years, namely operation at a reduced census due to COVID-19 and workforce challenges, and the introduction of the Crisis Prevention Response Team. Both have contributed to a significant decrease in CODES/Psychiatric Emergencies, subsequently decreasing patient injury (see graph below).



3. Extraordinary Barriers List: The EBL has decreased from 182 patients in September 2022 to 170 currently. DBHDS is committed to ensuring safe discharges that promote successful community living. DBHDS continues to develop strategies to support placements for patients requiring specialized essential supports prior to discharge.

4. Regarding the use of trauma-informed care (TIC) in response to increases self-injurious behavior: As noted in last year's DBHDS response to dLCV, there is a possible mischaracterization of trauma-informed care as DBHDS supports the effort to increase access to evidence-based treatments across modalities. Evidence-based group programming is the primary modality of treatment in hospital settings. There are many individuals who would benefit from individual psychotherapy, and we have a shared goal of increasing access to this service. Trauma-informed care is not just individual therapy, but also a philosophy and method of interacting as well as staff knowledge. Asserting that DBHDS facilities do not take into account trauma histories nor use the patient's reported soothing preferences is inaccurate. These details should be taken into account in next year's report to provide a more valuable view of how DBHDS can make improvements in this area.

5. Incident Timing: There is also a concern regarding the assumption of causality in several areas where it is more a matter of simple correlation. For example, there was an assumption that higher frequency of incidents between 4-6 p.m. may be related to staff shortages and lack of structured programming. If those variables were the driving factor for that specific time frame, it would also be true for other timeframes. That said, DBHDS strongly believes in continued quality improvement efforts, which include reviewing and analyzing incident data with timing to improve safety and service delivery.

6. Unknown deaths: As noted in last year's DBHDS response to dLCV, the reporting of deaths with reason unknown typically occurs when evidence is not sufficient to identify an official specific cause of death at the time the event notification is made. The established cause of death for all patients that expire in DBHDS state hospitals is determined by the local medical examiner, not by DBHDS. DBHDS Central Office is notified within 24 hours that a death occurred, or within 24 hours when the facility is made aware that a death has occurred. Medical examiner results of autopsies and external examinations reports are received by DBHDS or the state facilities months after initial notifications are made, and the cause of death is classified as unknown until the medical examiner delivers a report. These details should be taken into account in next year's report to provide a more valuable view of how DBHDS can improve in this area.

7. Deaths within 90 days: While dLCV acknowledges a decrease in deaths within 90 days, it is still described as a fundamental concern. As noted in DBHDS's response to dLCV last year regarding this measure, the conclusion based on the high number of deaths during the first 90 days without actual denominators, and using only death proportions, is not reliable, especially because the proportion of state facility patients who are there less or greater than 90 days is not accounted for. Again, a mortality rate (number of deaths/number of total patients under 90 days or over 90 days) would provide a more accurate statistical comparison. The inappropriate admission of medically ill patients to state hospitals as a result of the 'bed of last resort' legislation continues to be a concern. DBHDS state facilities are required to accept patients under a temporary detention order (TDO) when no other private in-patient psychiatric bed has been identified due to this legislation. Often this includes patients with complex medical issues that should be served in a private setting with access to appropriate medical supports. Since July 9, 2021, state hospitals have experienced limited bed capacity resulting in delayed admissions. During this time, law enforcement drop-offs of patients under a TDO has increased dramatically. In these circumstances, patients arrive at the state hospital without medical clearance, acceptance, or an available bed. There were 460 of these types of drop-offs in FY 2022. Complex medical issue patients with other comorbidities who are not medically cleared, are being taken to state hospitals where they are triaged and sent back to a community emergency department, as necessary, in an effort to prevent further harm. Suspected instances of EMTALA violations are reported, but rarely founded.

   In addition, state hospitals make every effort to admit forensic TDOs within the established timeframes as these patients are only served in that setting. Both civil TDO drop-offs and forensic TDO patients arrive at state facilities without prior medical clearance, and this may negatively impact patient outcomes and mortality. Both patients and staff are then placed at risk for negative outcomes and critical incidents. State hospitals perform patient assessments on their arrival and ensure they receive necessary medical care, including sending patients to

a private hospital ED for further evaluation and stabilization when needed. At any point during a patient's state hospital admission, hospital staff will seek additional medical support through ED visits and private hospital admission as warranted. These details should be taken into account in next year's report to provide a more valuable view of how DBHDS can make improvements in this area.

8. End of Life Care at State Facilities: Again, as noted in last year's DBHDS response to dLCV, patients in state facilities receiving end of life services are provided access to family and friends per documented disclosure agreements and commensurate with patient and authorized representative wishes. Palliative or hospice care patients may remain in the state facility on special hospitalization or be discharged to a medical facility. These decisions are made in collaboration with the patient, authorized representative, and treatment teams, in the best interest of the patient. Many patients have access to, and special arrangements are made whenever possible, for around the clock visitation. This is validated by the many families who express their gratitude for the end-of-life care patients receive at DBHDS facilities. Implying that patients are languishing in state hospitals without the opportunity to be discharged home is misleading and inaccurate as each circumstance is different for patients who may not have an appropriate placement to meet their needs outside of a hospital setting. Some patients may not have relatives at all, or relatives who are not willing to care for them at the end of their lives. Often hospice programs and facilities will not accept them due to worsening end of life behavioral issues, and state facilities are better equipped to allow greater access to visitation than home environments or other areas who do not have trained behavioral health staff. These details should be taken into account in next year's report to provide a more valuable view of how DBHDS can make improvements in this area.

9. DNR Status and deaths: DNR status does not equate to whether or not a death was preventable. As part of the DNR standard of care, every patient admitted to a state facility is asked at the time of admission, what their preference is should a life-threatening emergency occur that requires resuscitation. This occurs on admission and whenever a change in a patient's condition occurs where DNR status may be applicable. Any preference or change in preference is documented in the medical chart. It does not only occur "days before a death," as commented on in the report. When a serious medical event occurs, patient preference is updated based on the unique medical condition and circumstances, and in collaboration with other medical providers. A patient or authorized representative may choose continued attempts at resuscitation until days or even moments before the death occurs as dignity of choice is adhered to throughout these types of decisions.

10. Submission of Reports and Data: DBHDS Facility Services Division Leadership has reviewed reporting responsibilities and will submit reports to dLCV not received during the identified reporting period. This issue can be attributed to recent staff turnover; however, a plan will be implemented to ensure timely reporting moving forward.

Sincerely,

Nelson Smith
Commissioner