COMMONWEALTH of VIRGINIA

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August 12, 2013

Commissioner James W. Stewart, III
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, VA 23218

RE: *OSIG Inspections of the State Facilities Operated by the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to the Code of VA § 2.2-309.1*

Dear Mr. Stewart:

The purpose of this letter is to advise you of issues identified by the Behavioral Health and Developmental Services Team for the Office of the State Inspector General (OSIG) during the FY 2013 series of inspections of the state facilities operated by DBHDS. During the inspections, the BHDS team, referred to hereafter as the Team, concentrated on four key focus areas. The areas included the following:

1. Active discharge planning within the context of, and as a vital component to, overall individualized active treatment;

2. Staff concerns as evidenced by staff turnover rates and a facility's use of overtime;

3. Staff attitudes and knowledge to provide services consistent with DBHDS' expressed commitment to recovery and person-centered treatment; and,

4. Each facility's environmental compliance with the Human Rights regulations as 'safe, humane, and sanitary' environments of care in the context of other more global environmental factors.

The issues and recommendations identified in this letter are designed to improve service delivery and the effectiveness of the state-operated facility programs intended to support persons with behavioral health and/or developmental disabilities achieve maximum benefit from inpatient/long term residential treatment and to improve their quality of life.

The Team would like to express its appreciation to all of the dedicated professionals at the state-operated facilities and the DBHDS Central Office for their on-going commitment to the citizens of Virginia. We would like to thank the facilities' staff and Central Office leadership for the assistance and cooperation extended to us. We also want to acknowledge their courtesy, professionalism, and collaborative approach in working with us towards the goal of quality oversight and improvement.

METHODOLOGY

During April and May 2013, two teams made up of members of the OSIG audit, behavioral health staff, and consultants conducted unannounced inspections at each of the 16 facilities operated by DBHDS. Information was gathered through a number of activities and methods, which include, but are not limited to, the following:

- Surveys were completed with 657 clinical and direct care staff, with a focus on unit functioning, leadership support, and staff morale;
- Interviews were completed with 40 staff members at the facilities, including facility directors, safety personnel, and human resource officers;
- Surveys/Interviews with 38 persons serviced and/or their authorized representatives occurred with a focus on quality care, participation in active treatment, and discharge support;
- Completion of environmental checklists for at least three residential units at each facility, with a focus on issues of safety and quality of life;
- Review of staff scheduling across three shifts for a seven-day period, with a focus on staffing patterns and overtime;
- Completion of 184 record reviews with a focus on transition planning and transition follow-up;
- Observations of 36 treatment team meetings with a focus on active treatment and the active participation of persons serviced in goal setting and discharge planning; and
- Review of selected abuse and neglect cases, critical incidents, and risk management reviews.

OSIG OBSERVATIONS

Among the observations made by the Team during this series of inspections are the following:

- The behavioral health and developmental services facility system is experiencing significant changes in service delivery as a result of the Commonwealth's efforts to comply with the provisions of the Department of Justice (DOJ) Settlement Agreement. Much of the current focus and energy within the DBHDS Central Office is devoted to collating a myriad of activities while standing up programs and processes for addressing the multifaceted and complex Settlement Agreement enterprise. *(Refer to Issues Section)*

- While one of the initial voiced goals of the current DBHDS administration was to create an increasingly viable partnership between the Central Office, state-operated facilities, and community providers, this goal has been expedited by the Settlement Agreement. The effectiveness of this partnership was evident in the discharge planning and transition process currently underway at the training centers. *(Refer to Issue 1.A)*

- DBHDS developed Annual Consultative Audits within the behavioral health facilities as a process to forge stronger partnerships across the facilities and between the Central Office and the facility system. DBHDS leadership firmly believes these partnerships will have an enduring effect on the development of a more uniform and integrated system of behavioral health care. However, absent clear and relevant measurements, the effectiveness of the process could not be verified by the OSIG. *(Refer to Issue 4.A)*

- The creation of the Division of Quality Management and Development occurred in the midst of the Settlement Agreement process and as a result it has not had the opportunity to develop to its fullest capacity. Performance measures for a limited number of specified areas within the behavioral health and developmental services system are proceeding, but the priority demands of the quality measurement and monitoring requirements of the Settlement Agreement are receiving the most initial attention. *(Refer to Issue 4.A)*

- Other consequences of the DOJ Settlement Agreement that will strain the system and future planning demands on DBHDS include the closing of the training centers. The planned closure of Southside Virginia Training Center (SVTC) will potentially leave a long-term mark on the already blemished Petersburg campus that is rife with unused and deteriorating buildings. The already compromised physical aesthetics of Central State Hospital (CSH) will be further impacted by the planned closure. *(Refer to Issue 4.C)*

- The overtime (OT) at Central Virginia Training Center (CVTC) has been primarily a by-product of increased activities associated with Settlement Agreement processes. Even though CVTC's direct care staff accounted for 50% of the overall overtime within the training centers, the reasons for the OT were clearly delineated by facility leadership and not a result of mismanagement as previously noted by the OIG in 2010. *(Refer to Issue 2. A)*

- The readmission rate at the Commonwealth Center for Children and Adolescents (CCCA) has increased over the past 16 months. This trend presents concerns on several fronts. One, increased readmissions diminishes bed capacity and secondly, repeated admissions run the risk of undermining the therapeutic gains made by the children and their families, particularly if the benefits of hospitalization are not sustained because the greater provider community does not have the services to address the intense needs of the children being discharged from this acute care setting. The multifactor complexity of increasing community capacity presents numerous potential factors that could be measured to assess not only regional service needs but also the effectiveness of targeted service growth. However, few relevant measures exist. *(Refer to Issue 1.C)*

- The Virginia Center for Behavioral Rehabilitation (VCBR) is a unique facility in the behavioral health service system. The clinical mission of the facility has been primarily actualized through the development of sound therapeutic processes, a solidly forged relationship between security and clinical staff, and the commitment of facility and Central Office leadership to implement recovery-oriented principles in overall service delivery. The straddling of this facility's functioning somewhere between a correctional setting and a behavioral health facility presents distinct challenges that are not experienced by any other behavioral health facility. This is evident with the issues faced by the facility in addressing the housing (double-bunking) needs of the persons served and discharge planning. *(Refer to Issues 1.B and 4. B)*

IDENTIFIED ISSUES BY FOCUS AREA

In its May 2012 report to the Governor and General Assembly, the former OIG-BHDS identified five managerial and operational challenges DBHDS would face during FY 2013. Two of the identified challenges were focused on during this series of inspections. The Team found these challenges to remain significant issues for the agency. The challenges include the following:

- Assuring timely compliance with the DOJ Settlement Agreement; and
- Increasing system accountability.

The OIG stressed that focusing on the integrity of the new programs and expanded services, as well as the process for closing the facilities, are vital to ensuring that the overall compliance plan is carried out with economy and efficiency. The report noted the following:

> "It is essential that all partners identify and mitigate vulnerabilities to the successful completion of this endeavor by prioritizing oversight resources through the establishment of targeted timelines, quality indicators, and

> supportive data gathering and assessment through the establishment of outcome measures. In broad strokes, the factors necessary to actualizing the DOJ *Settlement Agreement*, require DBHDS and its partners assure that data systems supporting the programs are scrutinized for accuracy and timeliness; that ongoing staff and provider training regarding new program implementation and expansion occurs throughout the transition and beyond; that systems for accountability, transparency, compliance and risk mitigation are developed and monitored by multiple oversight authorities; and efforts to provide stakeholders with clear information and guidance as decision-makers in the creation of the newly established community system of care occur regularly."

While the court-appointed independent reviewer highlighted considerable progress by DBHDS, many of the issues identified in his April 2013 report reflected the concerns reported on in the OIG-BHDS Semi-Annual Report, such as the magnitude, complexity, and newness of some of the proposed programs, including crisis services for persons with intellectual disabilities (ID); the establishment of an effective internal and external quality and risk management system; and the accuracy of data gathering and assessment of outcomes and factors associated with delays in progress.

Much of the DBHDS resources and efforts are devoted to the successful implementation of the settlement agreement, which will have a durable impact on service delivery for persons with intellectual disabilities but, in the opinion of the Team, will also create an indelible shift of the service delivery system for all persons served.

Focus Area No 1: *Active Treatment and Discharge Planning*

1. A - Enhanced discharge planning and transitional services are well-developed at each of the training centers. In contrast, the process for discharge planning at the behavioral health facilities have less safeguards in place to assure successful community re-integration and continuity of care.

Discharge planning is viewed as a vital component of active treatment by accrediting and monitoring agencies and organizations that interface with the state facilities, such as the Joint Commission, Medicaid, and Medicare. It is also a key component of the 2012 Settlement Agreement between the Commonwealth and the Department of Justice (DOJ), which highlights that active treatment is designed to address the issues that resulted in the person's need for inpatient or long term residential treatment, the most restrictive levels of care, as well as identify the services and support that will be needed to enable the individual to establish and maintain successful re-integration into the community-at-large.

As a mechanism for complying with the DOJ Settlement Agreement, DBHDS established a number of transitional support activities. The activities included: the initiation of facility transition teams designed to provide support families and person served; educational and decision-making supports; enhanced discharge planning processes; and extended

community follow-up, including monitoring at 30 days intervals for up to three months. Additional safeguards, such as human rights and licensing involvement in placement and follow-up activities, support the creation of a culture of Central Office, facility, and community partnership in aiding the person achieve and maintain successful integration, which are unparalleled in the behavioral health care facilities.

It is the judgment of the Team that even though the behavioral health facilities have a structured process in place for discharge planning, the bifurcated process of determining readiness for discharge, a diminished focus on the recovering person's and other significant parties' participation in discharge planning, and a less comprehensive approach to transitional planning, including a more focused culture of partnership between the Central Office, facilities, and community providers, make discharge planning in the behavioral heath settings less effective.

1. B – A Person served at VCBR is not afforded the same system of transitional supports as an individual discharged from Virginia's other behavioral health facilities.

The uniqueness of VCBR among all DBHDS facilities is evident in the process involved with how individuals are deemed eligible for discharge/release. With the exception of some individuals admitted under a forensic status, DBHDS behavioral health facilities rely on a "clinically ready for discharge" process that involves agreement of facility and community services board or behavioral health authority (CSB/BHA) staff. Treatment is initiated on admission and efforts are made to transition the individual back to the community as soon as they are deemed to be clinically ready. CSBs and BHAs receive dedicated state general funds, in the form of discharge assistance allocations, to address unique and challenging needs that may be preventing a clinically ready individual from returning to the community.

Public safety concerns, reflected in Virginia laws crafted specific to VCBR, require a different and often more lengthy process for determining an individual's readiness to return to the community. The DBHDS Commissioner must prepare a report each year for the first five years of a resident's civil commitment and every other year thereafter if the individual is still committed to VCBR. That report, comprised of input from VCBR treatment staff reflects opinions regarding the totality of treatment and behavioral information from the previous year. The report is provided to the Office of the Attorney General, the individual's attorney, and the court that civilly committed the individual to VCBR. That court has sole discretion over granting a conditional release.

Individuals can be discharged either after completing the treatment program and receiving a recommendation for conditional release from VCBR, released by committing courts before completing the treatment program and without a recommendation from VCBR, or unconditionally released due to a change in their legal status, such as the program expressing their opinion that an individual is no longer a Sexually Violent Predator, or because they won an appeal of their civil commitment from the Virginia Supreme Court. As such, the path for leaving VCBR is much longer than that experienced in other DBHDS facilities. According to VCBR leadership, most individuals at VCBR will spend an average of five years if they are in treatment before conditional release. When release is

recommended and approved by the court, there are no funds allocated to CSBs and BHAs to help address barriers to community transition. The distinction of VCBR is further evidenced in the fact that DBHDS policies related to discharge planning do not require that CSBs or BHAs be actively engaged in the process. Interviews with facility and Central Office leadership stressed that there is no structured system for supporting continued treatment and successful community re-entry for this population.

Even though DBHDS plans on and is committed to filling a discharge planner position during FY 2014 to work with the facility in developing more coordinated transitional services and supports for individuals discharged from VCBR, without the funds to support this endeavor, the success of this effort will be limited.

It is the opinion of the Team that the lack of dedicated funding to support community transition for individuals deemed ready for release and approved by the committing court creates a risk of individuals remaining at VCBR much longer than necessary. Given the growth in admissions, as confirmed by the decision to implement a "double bunking" strategy for the facility, such delays will only exacerbate the overcrowding of VCBR and potentially increase tensions within the facility.

1. C - There has been an increase in readmission rates at the Commonwealth Center for Children and Adolescents (CCCA) over the past 16 months.

Interviews with facility and Central Office leadership acknowledged an increase in the readmission rate at CCCA over the past 16 months. Data provided by the facility shows that during FY 2013, 68 or 9.8% of all admissions are readmissions that occur within 30 days of discharge; and 166 or 24% of all admissions are readmissions that occur within 12 months following discharge.

The scope of the inspections did not include a study of the factors associated with this trend. It was the opinion of those interviewed that one factor contributing to this increase is the limited children's services capacity in the community to provide for the on-going and intensive needs after acute hospitalization at CCCA. Facility leadership reported that "of those readmitted within a year after discharge, 41% were admitted within the first month, suggesting that this is a critical period for readjustment to the post discharge setting. Some of these readmissions reflect less than adequate services following a return home, and some reflect poor, or less than adequate, adjustment to a group home or residential placement." Facility leadership went on to comment that " It is our sense as well that the nature of services and the speed with which they can be provided to kids and families are important factors influencing their post-discharge adjustment and, in some cases, risk for re-admission to the hospital. We are pleased that the Governor and General Assembly have allocated additional resources for community-based crisis stabilization services, which may also divert admissions."

CCCA had the highest bed utilization rate in the system for FY 2012; each bed in the facility "turned over" 20 times compared to the next highest "turn over" rate at Southwestern

Virginia Mental Health Institute (SWVMHI), which had a rate of approximately six times per bed. This is reflective of the average length-of-stay at CCCA being roughly 17 days. In order for CCCA to accomplish its mission and serve as the only state-operated facility for children and adolescents, it is the opinion of the Team, that examination of the factors that have resulted in the growth of the readmission rate will not only be vital for future planning and resource allocation for children's services, but preserve the facility's mission as an acute care setting, providing comprehensive diagnostic evaluations and rapid stabilization for the children needing intensive inpatient treatment.

Focus Area No 2: *Staffing Patterns, Turnover, and Overtime*

2. A – Central Virginia Training Center's (CVTC) direct care staff accounted for 50% of the overall overtime across the five training centers during the period between July 1, 2012 to March 31, 2013.

The number of hours of overtime (OT) among direct care providers (including direct service associates, registered nurses, and licensed practical nurses) across the five training centers during July 1, 2012 and March 31, 2013 totaled 325,697. CVTC direct care staff accounted for 50% or 163,298 OT hours. For this same time period, CVTC comprised about 36% of the training centers' census.

In 2010, the former OIG-BHDS conducted an investigation of overtime at the facility and concluded that the primary factor associated with the excessive overtime was facility mismanagement. Interviews with facility staff and leadership showed that the reasons for the current use of overtime are more easily identified and often connected with the processes associated with transitional and discharge planning related to the Settlement Agreement.

Facility leadership reported that "Many direct care staff members are going to visit homes pre-discharge in order to complete environmental assessments, conduct on-site training of peer staff, and support the individual adjust during overnight visits." Unlike any other training centers, CVTC serves individuals from 36 out of the 40 CSBs so staff members are engaged in more extensive traveling than the staff at the other facilities just to accomplish the same tasks.

Leadership shared that it was not uncommon for staff to travel "to and from Danville then to Alexandria and then to Gloucester, and so on." In addition the Team learned that several CVTC staff went by train to Florida to accompany an individual being transferred to a facility closer to his family. They stayed and trained the staff in his new home for a few days. Travel time, service provision and the coordination of care for this one individual resulted in a number of overtime hours.

Over the past few years community outings for small groups of individuals have increased. These outings are for recreation, vocational, and service activities, such as volunteering for

meals on wheels, taking homemade items to the nursing homes, stocking trucks, feeding animals at a local agency, and being on a crew to keep the local trails clean. Due to the acuity level of some individuals, increased staffing is needed to assure safety while engaged in these activities.

Other factors influencing overtime during this period, include the following:

- Assuring staffing coverage for individuals with behavioral challenges, which averaged around 1,456 hours a week. For example, an individual was admitted that required 2:1 or 3:1 staffing coverage in an exclusive living situation across all three shifts. Currently, that individual has been integrated into a suite with others, but still requires 2:1 staffing for two shifts.
- CVTC provides sitters whenever someone is hospitalized or in the facility's infirmary. Since early July 2012, the facility has had approximately 67 hospital admissions. Of these, five individuals were hospitalized for a total of 21 days, i.e. coverage for 63 shifts. Additionally, some of the hospitalizations took place at UVA, which required additional hours for travel time.
- Between December 19, 2012 and January 7, 2013, 37 persons served developed the flu. Some required infirmary admissions and others were hospitalized. Some of the suites were restricted to only staff members that work on those units to deter the spread of the flu to other residents and staff. This drained resources due to the required 1:1 coverage and the effort required to avoid cross contaminating other units. However, some staff members developed the flu and were not allowed back until medically cleared.

CVTC has initiated a number of practices to lessen the impact of OT on services and supports. Examples of actions are as follows:

- Several suites were closed, including all of Building 47. This allowed staff to be reassigned to other units and condensing the footprint of the facility.
- Management of the facility are reviewing staff scheduling patterns as they implement KRONOS (a program for project management including staffing needs) for better staff utilization.
- Management continues to actively recruit for direct care positions that are funded, but find this challenging because community programs often successfully recruit trained staff. This is impacted by the commonly known planned closing of the facility.

<u>Focus Area # 3: Staff Attitudes and Knowledge Regarding Recovery-Oriented and Person Centered Practices</u>

No issues were identified by the Team in this focus area. Staff surveys demonstrated that the respondents have become increasingly knowledgeable of recovery-oriented and person-centered principles. As a result there has been a measurable improvement in their

attitudes regarding the effectiveness of these practices on the persons served, particularly regarding community integration. The Team commends DBHDS for it efforts in this important area.

Focus Area No 4: *The Environment of Care*

4. A –The effectiveness of the Annual Consultative Audit process cannot be verified.

According to Central Office leadership, the Annual Consultative Audit (ACA) team "process was developed and is implemented by the operational divisions and is intended to improve information and idea sharing for quality improvement among hospitals and training centers by and for peers in a open and supportive, no-fault environment." DBHDS leadership recognizes the importance of partnership development among the facilities as a pathway to increase communication and eventually increase systemic effectiveness. The Team agrees that an increased focus on a shared vision and mission across the facility system will have an enduring effect on the growth of a more uniform and integrated system of behavioral health care.

In a speech to the Virginia Association of Community Services Boards (VACSB) in May 2013, Commissioner Stewart reported that "Important outcomes from this effort (ACA process) include such things as improved treatment planning with measurable goals, use of consistent educational tools, shared best practices, and more consistent focus on peer support." An effort to verify this information, particularly in the area of improved treatment planning was unsuccessful. OSIG staff was informed that DBHDS does not keep any documents relevant to the peer review process, so an actual performance improvement process does not exist at this time.

OSIG staff was informed that "As the Division of Quality Management and Development develops and refines specific performance and quality measures and indicators for the hospitals and training centers, it is expected that the ACA process will also focus on helping improve performance on those specific measures, using the same peer-support, formative, and collaborative processes." There is evidence that the Division is refining established and creating additional performances measures for publication by early Fall 2013. The Division was created during the midst of the Settlement Agreement process and, as a result, has not had the opportunity to develop to its fullest capacity, as the demands of the quality measurement and monitoring requirements of the Settlement Agreement are receiving the most initial attention.

4. B – Even though the practice of double-bunking residents at VCBR is viewed as more cost effective than either facility expansion or reopening the vacant facility still available in Petersburg, it is clinically challenging and has the potential of increasing safety risks.

Item 319.A.3 of the 2011 *Appropriation Act* requires the Commissioner to develop strategies for actualizing specific provisions, such as "double-bunking" of the VCBR population, so that

the census of the facility increases from its original capacity of 300 individuals to 450. Current projections indicate that the facility will reach the proposed census of 450 residents before 2015. The census on April 4, 2013 was 309 residents. At that time, 32 rooms were occupied with two residents in each.

The facility, originally designed for single-room occupancy, was retrofitted from the initially designed 87 square feet per resident to 43.5 square feet. This was accomplished by removing a desk and chair, adding a shelf bunk with access ladder, and a metal wardrobe to house the second occupant's clothing or other belongings.

VCBR security and treatment staff expressed concern about the negative impact of double bunking, particularly as the facility's census increases. The square footage for double occupancy room are comparable to space allotments for facilities operated by the Department of Corrections, but falls short of the square footage recommended for persons in other behavioral healthcare facilities, which is approximately 100 square feet per person.

To address potential clinical and security concerns, VCBR established a Housing Committee. The Housing Committee is comprised of VCBR's Clinical Director, Director of Program Services, Chief of Security, Residential Services Director, Director of Nursing, and Resident Records Manager. The committee is chaired by the VCBR Housing Coordinator whose sole role is to review and process housing requests. The Committee meets regularly. A clinical staff member must be present when residents are involved in the meetings.

A pre-admission classification process has been established to determine levels of risk associated with double bunking, such as medical challenges, mental and physical impairments, psychiatric factors and security risks. OSIG staff was informed that "once the assessment is completed, if the resident is to be double bunked, the resident is paired with another prospective resident. This initial pairing is done by the committee and is based on Risk Factors (low assessments can go with medium or low, medium can go with any, high can go with high or medium, but never low). After this, the prospective pairing is sent to the Treatment Team of both of the residents who review and give a final determination." Once every six months, a resident may request to be moved if not satisfied with the arrangement. The OSIG has received one complaint to date associated with the issue of double-bunking. As placement options diminish through normal census growth, the committee will naturally become less effective in making roommate pairings that can address both the clinical and security risks of doing so.

Interviews with and documentation received from clinical staff and facility leadership outlined a number of clinical challenges/concerns with double-bunking. Among the concerns were the following:

- Treatment of sexually-violent predators (SVP) is highly individualized as each person has limits to the types of "media" access they have, particularly in the early stages of

treatment. For example, double-bunking could possibly force a resident to be around external high risk factors, such as photos of children or other "trigger" objects.

- It is contraindicated in a group of residents with poor control over their sexual impulses to be forced to share a space because sexual contact between residents is disallowed.
- Double-bunking also increases liability for possible sexual aggression between residents, particularly for residents who are too passive to report that it is happening to them.
- There are residents at the facility who are HIV positive and staff cannot share that information with the other residents, placing a roommate at potential risk.
- A high bunk presents a hanging risk and Virginia's SVP population has a higher rate of mentally ill residents than other states.
- Residents with mental illness often require increased personal space, particularly when acutely ill, so as to minimize the risk of misinterpreting the actions of others.

In addition to the clinical concerns, the facility, itself, was designed to accommodate a maximum of 300 individuals. This means that the structure was not designed with enough staff office space, group rooms, educational classrooms, recreational space, library or vocational space for the expanded census. This alone changes the effectiveness of overall treatment.

4. C – Facility and Central Office leadership acknowledged that the Petersburg campus will be impacted by the closing of Southside Virginia Training Center. The campus currently comprises Hiram Davis Medical Center (HDMC), Central State Hospital (CSH), and Southside Virginia Training Center (SVTC).

SVTC is the first training center scheduled to close as a part of the Settlement Agreement. The projected date for closure is June 2014. It was estimated by the Central Office that the cost of closing the facility will be $7,543,935 by the end of FY 2014 and approximately $9,925,928 by 2023. The total cost of closing all the facilities was projected at $60, 484,558 by 2023.

Eighty discharges were completed during FY 2013. Of these, two had to re-enter the facility for specialized care. Of the ten authorized representatives contacted as a part of the facility inspection, six reported being reluctant to agree to community placement and four of the six further indicated resentment that the state was adamant about closing the institution. Despite their reluctance, seven of the ten signified a willingness to participate in the educational process to gain an understanding of community options.

One unintended consequence of the closing of the facility on the Petersburg campus is further erosion of the campus' appearance. The Petersburg campus consists of approximately 600 acres with 300 of those identified as SVTC property. This includes two cemeteries; one of which is unmarked. Interviews with facility and Central Office leadership revealed that there has been little interest in purchasing the buildings or land beyond small parcels, such as ten acres. The proposed boarding up of the buildings owned as part of the

SVTC campus will only add to the already uninhabited appearance of the general campus. This is particularly true for Central State Hospital, which is already surrounded by old dilapidated buildings; several of which are literally falling down. Not only are the buildings an eyesore, but they pose potential safety risks.

RECOMMENDATIONS

Focus Area No 1: *Active Treatment and Discharge Planning*

1. A – It is recommended that DBHDS review options for enhancing the discharge planning process in the behavioral health facilities by adopting initiatives developed for the training centers.

1. B – Consistent with public safety and sound clinical practice, it is recommended that DBHDS develop a strategy for aligning discharge/release protocols and programs for VCBR residents with those of other DBHDS facilities.

1. C – It is recommended that DBHDS' Division of Children's Services conduct a study of the factors that have resulted in the increased readmission rate at CCCA. At the study's conclusion, it will be important to develop strategies for reversing this trend, as well as assessing the effectiveness of the currently funded treatment programs to assure that the limited resources are being utilized in the most effective manner.

Focus Area No 2: *Staffing Patterns, Turnover, and Overtime*

2. A – It is recommended that DBHDS Central Office, in conjunction with CVTC facility leadership, develop strategies for addressing the unique challenges in staffing for this facility with a focus on mitigating the negative effects of excessive overtime on staff.

Focus Area No 4: *The Environment of Care*

4. A – Enhanced performance measures are still needed in many process areas of DBHDS service provision. It is recommended that DBHDS develop and publish a plan for addressing performance enhancement of the state-operated facilities, including measureable objectives so that publicized outcomes can be verified.

4. B – No recommendation is offered at this time. OSIG staff will monitor the use of double-bunking as census growth continues.

4. C – It is recommended that DBHDS develop a plan for addressing the impact of the closure of SVTC on the Petersburg campus, particularly as it relates to CSH.

CONCLUSION

As previously mentioned, this letter is primarily intended to highlight where improvement is needed. However, the OSIG fully recognizes that this a uniquely challenging time in terms of systemic reform and, as such, acknowledges that DBHDS has sustained and successfully initiated multiple services that have and continue to be beneficial for the well-being of both service providers and recipients.

This letter is a public document, all or part of it may be used by the OSIG as a component of its reporting requirements. Our office would appreciate written comments regarding the recommendations no later than August 23, 2013. If representatives of DBHDS would like to discuss the identified issues and subsequent recommendations, members of the Team are available for that purpose. For assistance in arranging a time for a discussion to occur, please contact Cathy Hill, Senior Project Manager, at 804-432-4277.

Sincerely,

Michael F. A. Morehart
State Inspector General

CC: The Honorable William Hazel, M.D.
Secretary of Health and Human Services