JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

December 13, 2023

Virginia's State Psychiatric Hospitals

Behavioral Health Commission Briefing

Study resolution

- Review state psychiatric hospitals, including:
  - admissions criteria and utilization trends
  - alternative placements for some patients
  - staffing
  - patient safety and treatment quality
  - discharge criteria and planning process
  - DBHDS oversight

Commission resolution (November 2022)

Primary research activities

- Analyzed data on state hospital admissions, discharges, and patient safety incidents
- Surveyed state hospital staff and CSB staff
- Visited all state hospitals and several private hospitals
- Interviewed key stakeholders in Virginia and nationally
  - state hospital leadership and staff
  - staff at DBHDS, other state agencies
  - representatives of private hospitals and advocacy groups
  - national experts
- Reviewed national research and other states' approaches

In brief

State psychiatric hospitals' lack of control over admissions, including for patients who would not benefit from psychiatric treatment, places patients and staff at risk.

Many private psychiatric hospitals could admit more patients without exceeding safe operating levels.

An increase in forensic patients at state hospitals, especially for competency restoration, has significantly reduced beds available for civil admissions.

Concerns related to pay, personal safety, scheduling, and support from hospital leaders are driving state hospital staffing difficulties.

In brief (cont'd)

Staffing difficulties have led to increased overtime and contractor costs and contributed to unsafe environments.

Physical incidents between patients occur at every state hospital, and ensuring patient safety is difficult because of high patient volumes, the characteristics and mix of patients, staffing challenges, and facility deficiencies.

Despite recent efforts undertaken by DBHDS, the Commonwealth Center for Children and Adolescents continues to have operational and performance issues, and operational costs have increased substantially.

In this presentation

Background

Civil admissions to state psychiatric hospitals

Civil admissions to privately operated hospitals

Forensic admissions to state psychiatric hospitals

State psychiatric hospital staffing

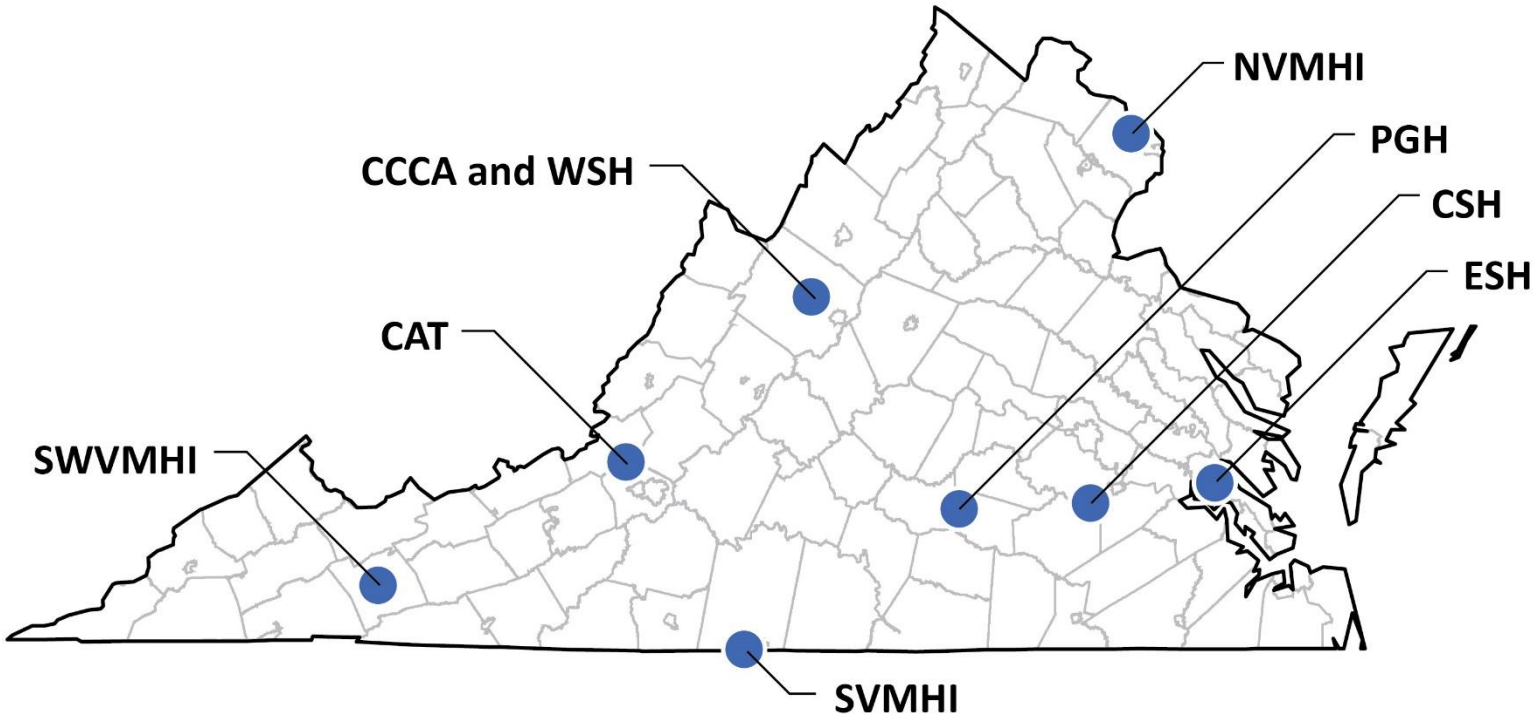
Ensuring patient safety

Commonwealth Center for Children and Adolescents

State hospitals intended to be the last resort placement for seriously mentally ill individuals

- State hospitals provide short- and long-term inpatient psychiatric treatment for individuals with a serious mental illness
- Various sections of state law require that patients be admitted to state hospitals only after all other treatment options have been considered
- About 5,000 patients were admitted to state hospitals in FY23, almost all involuntarily
- State general funds comprised 89% of total funding for state hospitals in FY23 ($495 million)

Virginia operates nine state psychiatric hospitals; eight for adults, one for children and adolescents



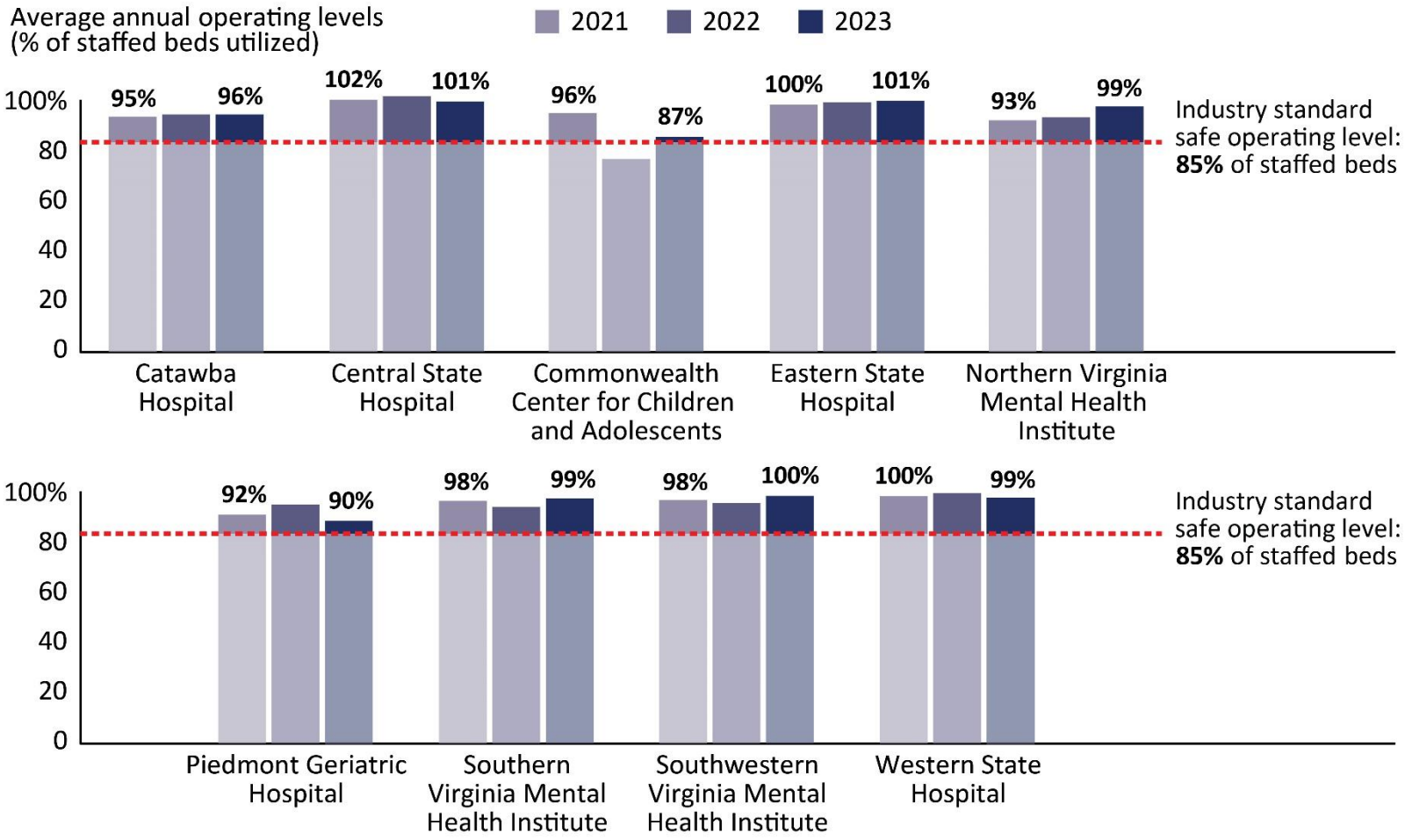
Note: CAT = Catawba Hospital, CCCA = Commonwealth Center for Children and Adolescents, CSH = Central State Hospital, ESH = Eastern State Hospital, NVMHI = Northern Virginia Mental Health Institute, PGH = Piedmont Geriatric Hospital, SVMHI = Southern Virginia Mental Health Institute, SWVMHI = Southwestern Virginia Mental Health Institute, WSH = Western State Hospital.

Patients may be admitted from the community or through the criminal justice system

- 53% of patients admitted to state hospitals are from the community ("civil admissions")
  - Temporary detention order (TDO) (*shorter-term involuntary treatment)*
  - Civil commitment order *(longer-term involuntary treatment)*
- Patients are also admitted from the criminal justice system ("forensic admissions")
  - Inpatient competency restoration for criminal defendants
  - TDOs for jail inmates, treatment for NGRI acquittees

Note: NGRI = not guilty by reason of insanity

State hospitals have been operating at levels considered within the industry to be unsafe



High operating levels at state psychiatric hospitals have contributed to civil and forensic waitlists

- In FY23, 8,538 individuals under a civil TDO were placed on the state hospital civil waitlist
  - Needed inpatient treatment
  - At least 235 were never admitted to an inpatient facility for further evaluation or treatment—instances the 2014 Bed of Last Resort law was intended to prevent
  - Prolonged waits adversely affect patients, law enforcement, emergency rooms
- From March 2023 through July 2023, 508 criminal defendants were delayed admission to a state hospital
  - At least 16 states have been sued for similar delays

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Individuals may be admitted to state hospitals involuntarily through civil commitment process

- Individuals may be admitted under civil TDO or civil commitment if they are imminent threat to self or others due to a mental illness and need inpatient treatment
  - Other facilities, including private psychiatric hospitals, must be considered first
- Before admission, all individuals must first be evaluated by a CSB preadmission screening clinician
- Civil admissions accounted for around half of admissions in FY23

Note: TDO = temporary detention order; CSB = community services board

2014 Bed of Last Resort law removed state hospitals' ability to deny civil admissions

- Under current law, state hospitals do not have the authority to deny admission to an individual under a civil TDO, even if the admission is inappropriate or unsafe
- Inability to deny admissions applies only to state psychiatric hospitals and started in 2014
  - Private psychiatric hospitals are prohibited under state regulations from admitting patients if they cannot adequately care for them
  - Law superseded state hospital admissions policies designed to ensure appropriate and safe admissions

Finding

Individuals who do not need psychiatric treatment are being placed under TDOs and admitted to state psychiatric hospitals, risking their safety and complicating hospital operations.

Some who do not need or benefit from inpatient psychiatric treatment are being admitted

- Individuals solely with
  - neurocognitive disorders (e.g., dementia)
  - neurodevelopmental disorders (autism spectrum disorders, developmental disabilities)
- Often placed on the same units as patients with serious mental illnesses and are at increased risk of victimization
- These admissions delay the individual's receipt of more appropriate treatment and complicate state hospital efforts to maintain safety for all patients
- Frequently reported as a concern by state hospital staff

Placements of these individuals allowed under current law's broad definition of "mental illness"

- Individuals may only be placed under a TDO or civilly committed if they have a "mental illness," as defined under state law
  - Current definition can allow individuals who solely have a neurocognitive or neurodevelopmental disorder to meet the criteria for a civil TDO or civil commitment
- Other states specify in law that neurodevelopmental and neurocognitive disorders are not mental illnesses
- Individuals with these disorders comprise a relatively small proportion of total state hospital admissions, but use disproportionately more bed days

Recommendations 1, 2, and 3

The General Assembly may wish to

(i) specify that behaviors and symptoms that are solely a manifestation of a neurodevelopmental disorder or neurocognitive disorder, as determined by a qualified and competent mental health professional, are excluded from the definition of "mental illness" for the purposes of temporary detention orders and civil commitments;

(ii) allow state hospitals to have a licensed mental health professional re-evaluate a patient before admission if the facility has reason to believe their symptoms or behaviors are solely a manifestation of a neurocognitive or neurodevelopmental disorder; and

(iii) delay the enactment of both provisions until July 2025.

Recommendation 4

The General Assembly may wish to consider directing the secretary of health and human resources to (i) evaluate the current availability of placements for individuals with neurocognitive and neurodevelopmental disabilities who would otherwise be placed in a state psychiatric hospital; (ii) identify and develop alternative strategies to support these patient populations, including, but not limited to, enhanced Medicaid reimbursements and a Medicaid waiver for individuals with neurocognitive disorders, and (iii) report the results of its work no later than October 1, 2024.

Finding

Law enforcement “dropoffs” are placing patients and state hospital staff at risk.

Law enforcement dropoffs have become more common since the beginning of FY22

- In FY22 and FY23, 1,432 individuals were dropped off at a state hospital by law enforcement before the hospital accepted them for admission
- Some individuals who were dropped off were experiencing urgent medical needs that state hospitals are not equipped to treat, according to hospital staff
- OAG opinion (January 2023) concluded dropoffs are not permissible under state law, but they continue

OAG = Virginia Office of the Attorney General

State hospital staff repeatedly raised concerns about patient safety related to dropoffs

- "There have been no deaths as a result of dropoffs, but it's been very close. Had a patient who we sent out 15 minutes after arrival who was very close to death. We feel lucky that there hasn't been a catastrophic outcome." – *State hospital staff*
- "Dropoff of patients by law enforcement is a frequent event at [this hospital]… I fear a patient will pay for this reckless behavior with their life." – *State hospital staff*

Recommendation 5

The General Assembly may wish to consider allowing state hospitals to delay admission of an individual under a temporary detention order until the state hospital has determined the individual does not have urgent medical needs that the state hospital cannot treat.

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Private psychiatric hospitals play an integral role in Virginia's overall behavioral health system

- In FY22, around 49,350 adults were discharged from a private psychiatric hospital in Virginia—10 times as many as admitted to state hospitals (~5,000)
  - Private hospitals operate about 53% of all beds for adults
- Attempts must be made to use private hospital bed first
- Best available data indicates that the majority of patients under a civil TDO are served by a private hospital
  - Data will be available through VHI starting in 2024 to understand the number of TDO admissions by hospital

Note: "Private psychiatric hospitals" include freestanding hospitals and psychiatric units in general hospitals that are licensed by DBHDS. VHI = Virginia Health Information

Finding

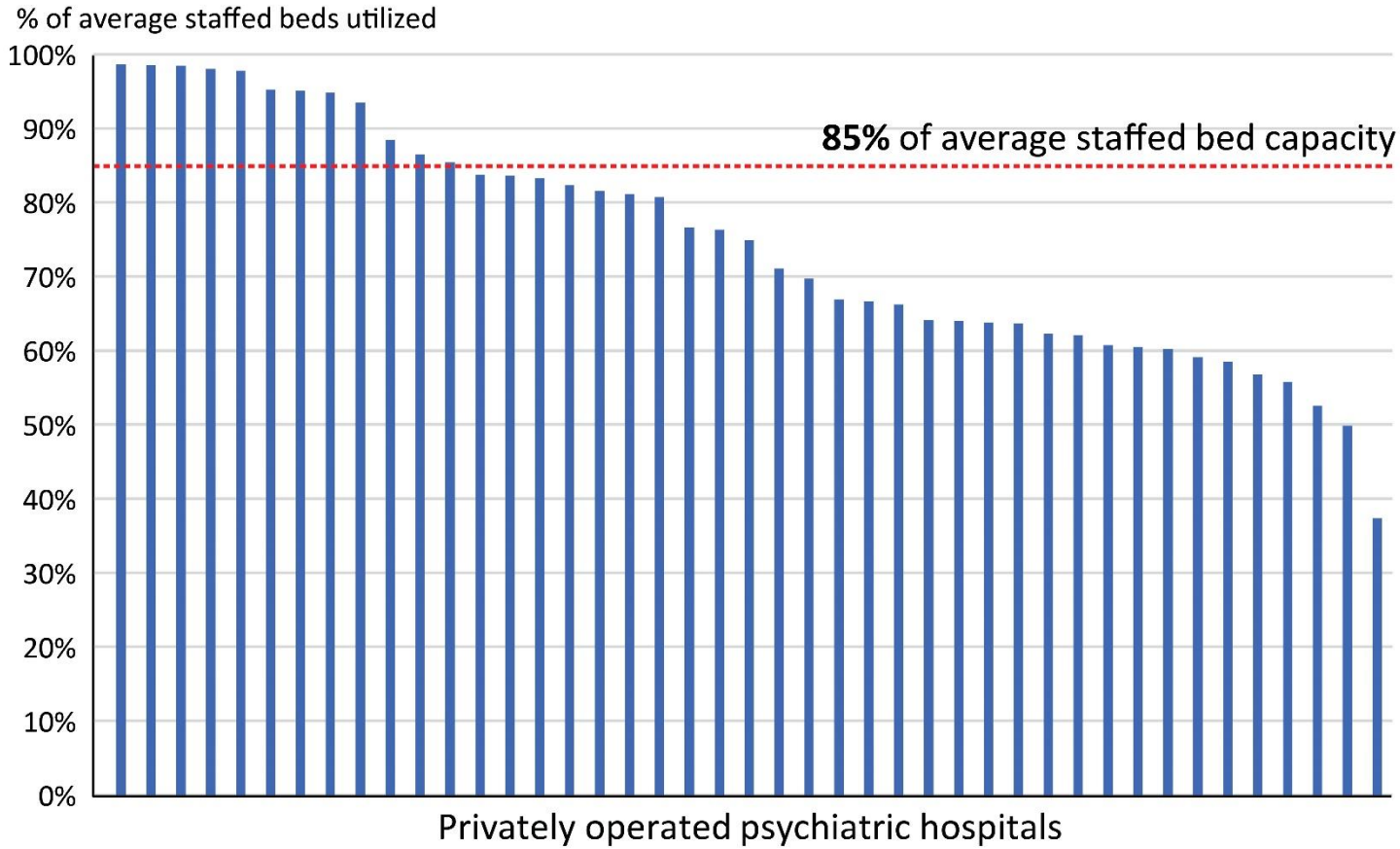
Many private psychiatric hospitals could admit more involuntary patients without exceeding safe operating levels.

Safe operating capacity for psychiatric hospitals is generally accepted as 85% of staffed beds

- According to industry standards, psychiatric hospitals generally should not operate at more than 85% of their "staffed bed capacity*"
- Unoccupied 15% capacity allows facilities to respond to rapidly changing needs, for example
  - Admission of a patient who is aggressive and who needs a single-occupancy room
  - Admission of several patients who need staff exclusively assigned to them for monitoring

*Staffed bed capacity refers to the number of patient "beds" that can be safely occupied given the facility's staffing levels. *Staffed* bed capacity will be lower than *total* physical bed capacity when there are not enough staff to safely utilize all patient beds in the facility.

In 2022, 31 of 43 private hospitals used less than 85% of their average staffed bed capacities



Source: JLARC analysis of data from the Virginia Health Information Annual Licensure Survey Dataset (2022).

Underutilization places avoidable burdens on patients, law enforcement, and state hospitals

- Underutilization of private psychiatric hospital capacity
  - contributes to avoidable delays in patient treatment and increases the likelihood that patients do not receive treatment at all
  - prolongs law enforcement involvement in TDO cases
  - unnecessarily occupies beds in emergency departments
  - contributes to unsafe operating levels at state hospitals
- Using some excess private hospital capacity in 2022 would have allowed private and state hospitals to operate within 85% of their staffed bed capacities

Recommendations 7 and 8

The General Assembly may wish to consider:
(1) establishing a program for private psychiatric hospitals to help pay for costs associated with improving their ability to safely admit patients under a TDO or civil commitment;
(2) including language and funding in the Appropriation Act to make private hospitals eligible to receive funding to help with discharging challenging patients.

Virginia could use COPN process to ensure private hospitals accept TDO patients

- State law requires healthcare providers to receive a COPN from the state health commissioner before establishing, expanding, or relocating inpatient psychiatric facilities
- In recent COPN applications, some private psychiatric hospitals have committed to accepting TDO patients
- State law should require applicants to agree to serve patients under a TDO as a condition of approval for future COPNs for inpatient psychiatric facilities
  - Similar to existing COPN requirements for charity care

COPN = certificate of public need

Recommendation 9

The Virginia Department of Health should develop and implement a process to (i) determine whether all healthcare providers that were granted a COPN based at least partially on their commitment to accept patients under a TDO are fulfilling this commitment, and (ii) take appropriate remedial steps to bring providers who are determined not to be fulfilling their commitment into compliance.

Recommendation 10

The General Assembly may wish to consider requiring the Virginia Department of Health to condition the approval of any certificate of public need for a *future* project involving an inpatient psychiatric service or facility on the agreement to accept patients under a temporary detention order whenever the provider has the capability and capacity to do so.

Recommendation 12

The General Assembly may wish to consider granting state psychiatric hospitals the authority to decline to admit any individual under a TDO if doing so will result in the hospital operating in excess of 85% of its total staffed capacity. The legislation's effective date should be delayed until July 2025.

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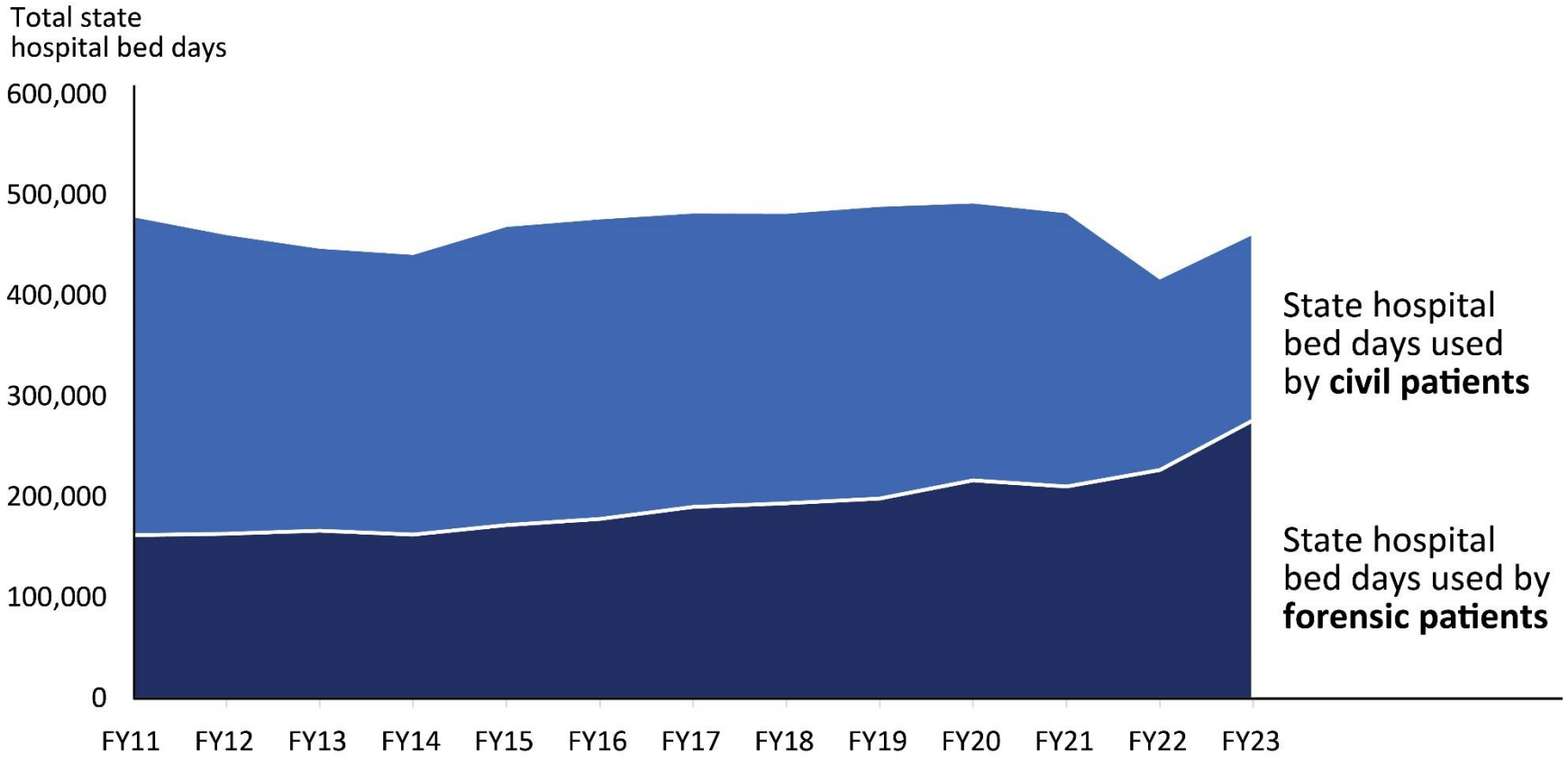
Forensic patients now use a majority of available state hospital capacity



Finding

An increase in competency restoration patients at state hospitals has reduced the capacity for civil admissions and contributed to unsafe operating levels.

Growing number of patients are being admitted for competency restoration

- Inpatient competency restoration services are provided only at state psychiatric hospitals
- Competency restoration admissions to Virginia state hospitals have tripled in the past 15 years
  - By far, the largest proportion of forensic admissions
- Median length of stay for competency restoration patients increased between FY13 (54 days) and FY23 (76 days)
  - About three times the length of stay among civil patients
  - Reduces number of patients hospitals can serve each year

Virginia relies heavily on costly inpatient competency restoration services

- In FY22, 73% of competency restorations were performed on an inpatient basis at a state hospital
  - Remaining 27% were provided on an outpatient basis by CSB staff, either while the defendant was awaiting trial in jail or in the community
- Inpatient competency restoration services are expensive
  - Inpatient: $110,000 per person
  - Outpatient: $1,190 per person

Note: Cost estimates reported by the Behavioral Health Commission (December 2022)

DBHDS could contract with private hospitals to provide inpatient competency restoration

- State law does not require that forensic patients be served exclusively at state hospitals
  - "any inmate of a local correctional facility may be hospitalized for psychiatric treatment *at a hospital designated by the Commissioner [of DBHDS]"* (emphasis added)
- Authority has not been exercised in recent years by DBHDS commissioners

Shortage of evaluators contributes to prolonged stays for some competency restoration patients

- A forensic evaluation is required before competency restoration patient may be discharged
  - Forensic evaluation performed by psychiatrist or psychologist with specific training
- Some state hospital patients stay longer than necessary solely because of a lack of enough forensic evaluators, according to state hospital staff
- DBHDS has taken steps to increase the number of evaluators, but the extent of delays due to shortage is unknown

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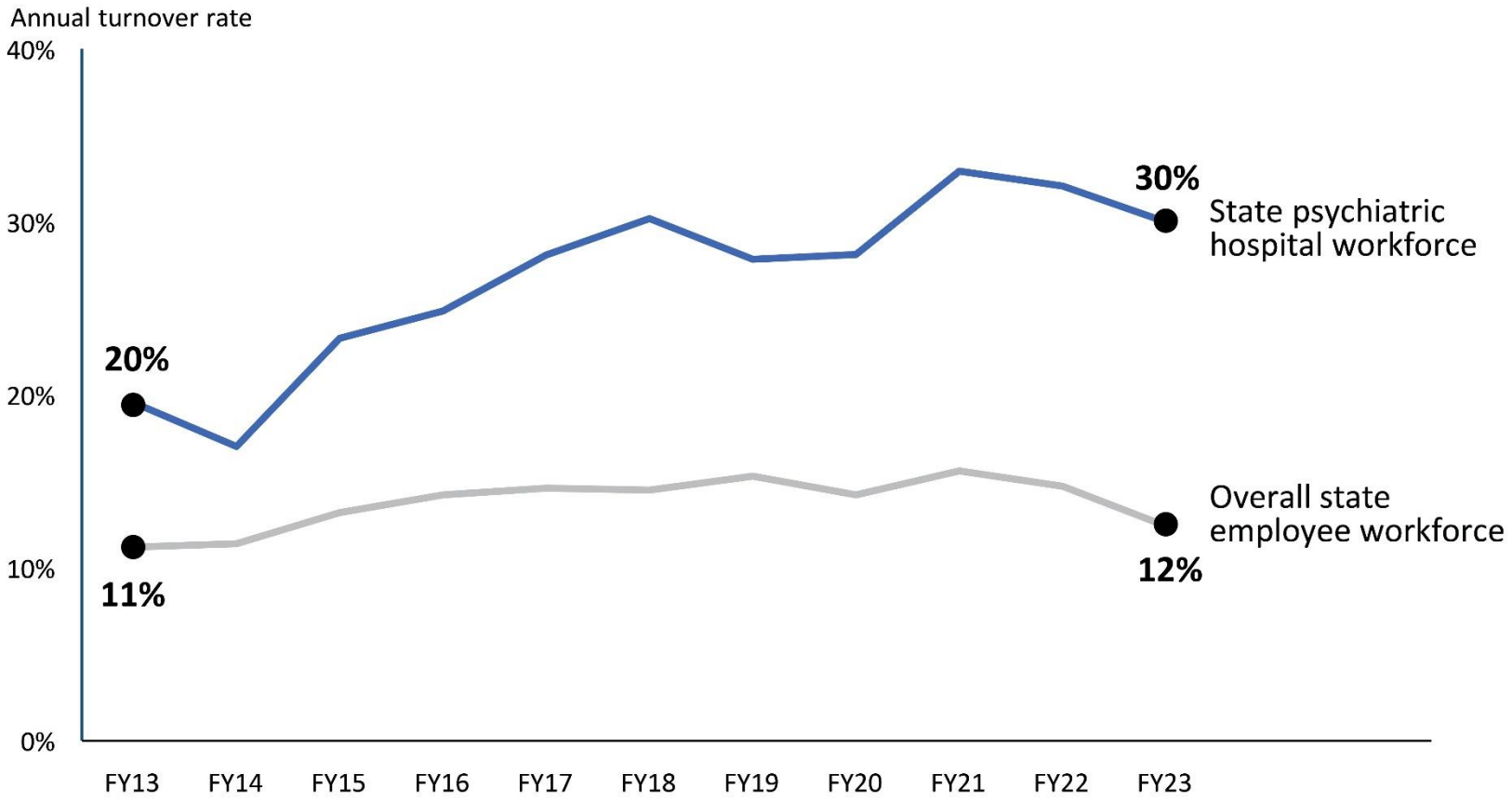
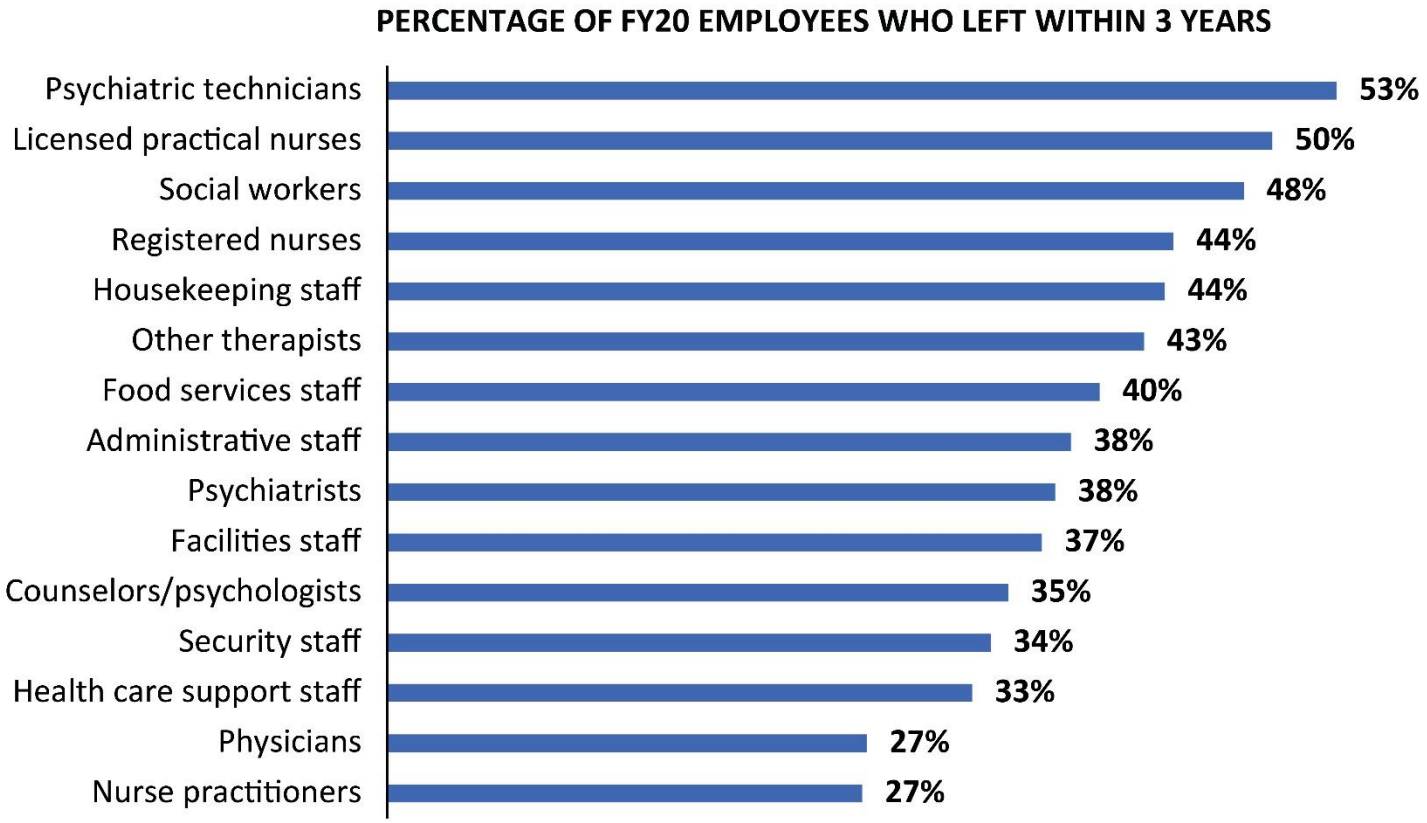
Finding

State hospitals struggle to recruit and retain staff, especially for certain clinical and nursing positions, and retention and recruitment challenges have increased over the past decade.

State hospitals have experienced higher annual turnover rates than the broader state workforce

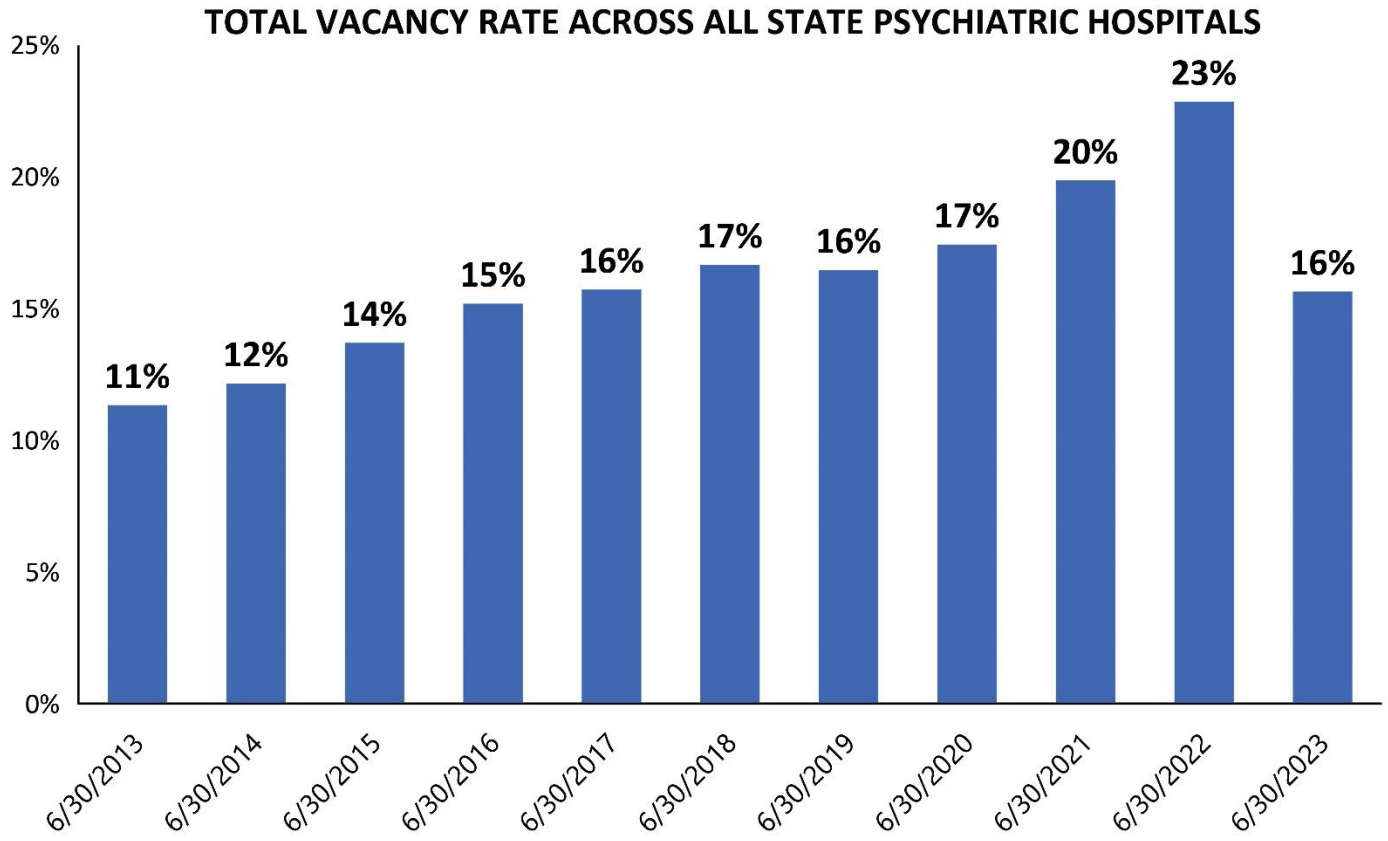


Recent turnover has been highest among nursing staff and certain clinical and support staff



Note: “Nursing staff” includes psychiatric technicians, licensed practical nurses, and registered nurses.

State hospital vacancy rates have also increased over the past decade



Note: Figure shows vacancy rates among full-time staff positions that were not filled by either full-time staff or a temporary contract position.

Staffing challenges have driven increases in state hospital costs and quality and safety issues

- Total state hospital spending on contractors and overtime increased from FY13 to FY23
  - Contractor spending: $4 million to $47 million
  - Overtime spending: $8 million to $20 million
- Staffing shortages are contributing to decreased quality of care and increased safety risks, according to state hospital staff
  - 57% of nursing and clinical staff responding to JLARC survey reported their hospital was insufficiently staffed

Note: Spending figures adjusted for inflation.

Finding

Concerns related to pay, scheduling, personal safety, and support are driving state hospital staffing difficulties.

Uncompetitive pay for certain positions appears to be a key reason for staffing difficulties

- 46% of all surveyed state hospital staff reported being dissatisfied with their salary or wages
- Uncompetitive pay was the leading reason why surveyed staff reported planning to leave within the next 6 months
- Available benchmarking data indicates that at least some roles are paid at less-than-competitive rates
  - Psychologists, social workers, housekeeping, food services

Unsafe working conditions and lack of support also cited as key reasons for turnover

- About half of surveyed nursing and clinical staff reported that their state hospital was not a safe place for staff
- In FY22, state hospitals had *seven times* the rate of paid workers' compensation claims as other state agencies
- Inadequate support from supervisors and leadership was also cited as a primary reason nursing and clinical staff were planning to leave their jobs

Inflexible scheduling is also a substantial contributor to nursing staff dissatisfaction

- 55% of surveyed nursing staff believed their hospital's scheduling strategy was problematic
- Inability of hospitals to offer 12-hour shifts to employees, a common practice in the healthcare industry, was a frequent complaint
- State hospitals can offer 12-hour shifts, but current state policy makes doing so less desirable for staff
  - If a state employee works fewer than 40 hours per week, their pay, leave, and retirement benefits must be reduced proportionately

Recommendations 17, 18, 19, and 20

The General Assembly may wish to consider

(i) providing salary increases for psychologists, social workers, housekeeping, and food services staff;

(ii) directing DBHDS to report annually to the BHC on average turnover and vacancy rates by hospital and position type, for the state's psychiatric hospitals;

(iii) directing DHRM to allow state hospitals to define nursing staff (including psychiatric technicians) who work at least 36 hours per week as full-time staff; and

(iv) providing funding to DBHDS to procure scheduling software to assist state hospitals in scheduling nursing shifts.

Nursing staffing levels at state hospitals appear lower than needed to provide intensive care

- Common industry measure of staffing level adequacy is nursing hours per patient day (HPPD)
- In 2022, workgroup of state hospital nursing leadership determined between 9.1 to 13.2 HPPD were needed to provide adequate care, depending on the type of unit
  - Statewide HPPD at state hospitals was 6.8 in FY23
  - Lower than staffing levels needed for *least* intensive unit
- DBHDS does not have funding for hospitals to meet the 9.1 HPPD and has not requested funding to achieve it

Recommendation 21

The General Assembly may wish to consider increasing the number of nursing positions allocated to state psychiatric hospitals to a level that would ensure adequate and safe patient care, as determined by DBHDS in 2022, and appropriate funding necessary to fill those positions.

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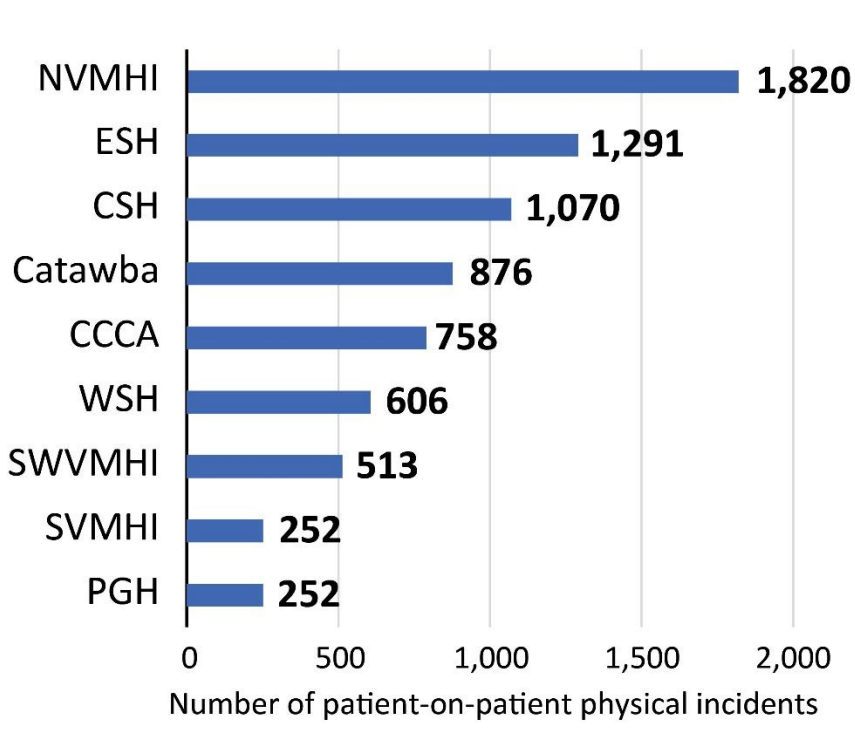
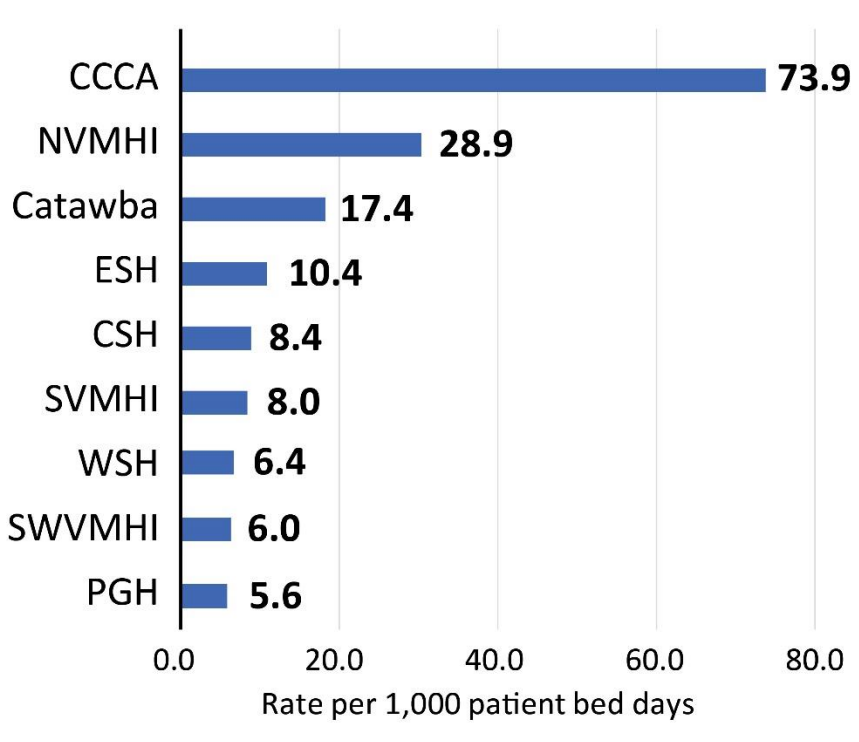
Patients in state hospitals are entitled to safe environments under state law

- State and federal law entitles patients to specific human and legal rights
- Patient safety and rights at state hospitals are overseen or otherwise monitored by several entities
  - DBHDS Office of Human Rights
  - The Joint Commission (a national accreditation agency)
  - The Office of the State Inspector General
- Hospitals conduct their own investigations of incidents, but DBHDS has a process to review their investigations

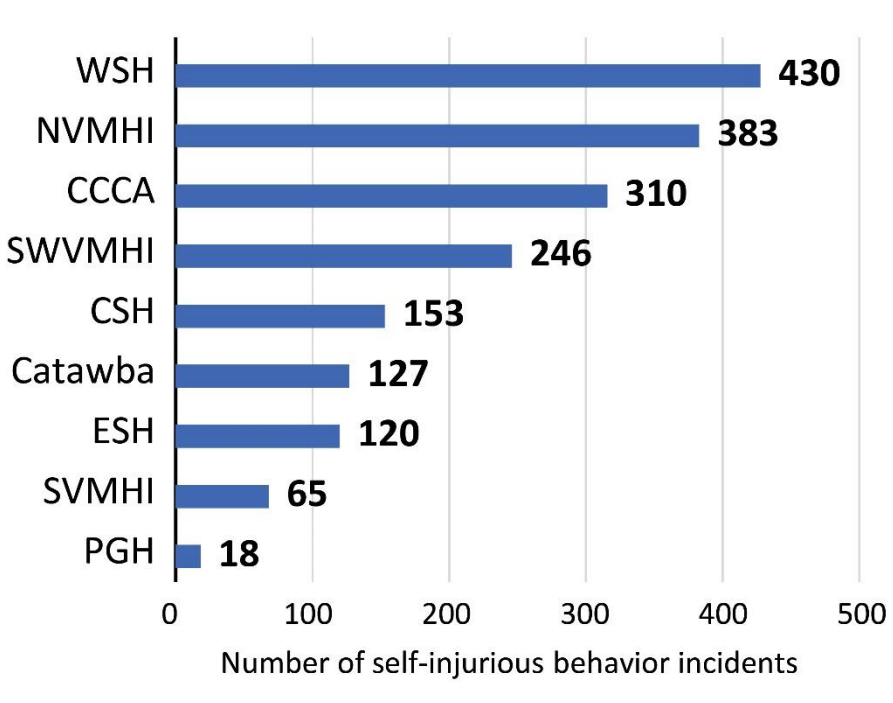
Rate of patient-on-patient physical incidents varies across hospitals (Jan. 2022 – May 2023)

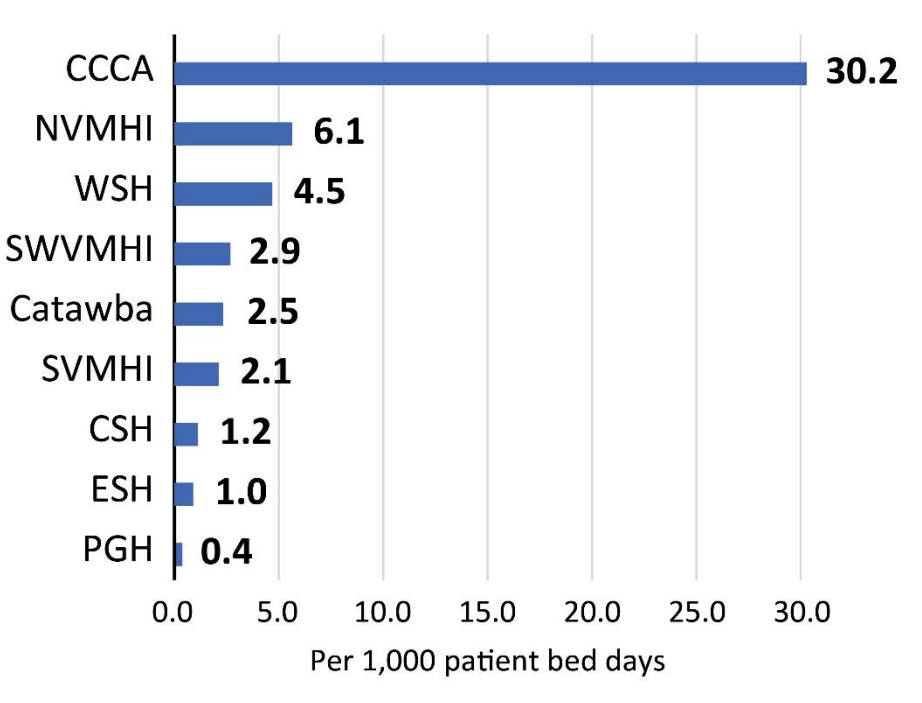




Note: “Patient bed days” refers to the total number of days that patients occupied a bed over the time period. It is used to allow for comparability of incidents across facilities of various sizes.

Number and rate of self-injurious behaviors also vary across hospitals (Jan. 2022 – May 2023)





Note: "Patient bed days" refers to the total number of days that patients occupied a bed over the time period. It is used to allow for comparability of incidents across facilities of various sizes.

Various factors make ensuring patient safety at state hospitals especially challenging

- State hospital staff reported certain common factors that make it especially challenging to keep patients safe
  - High numbers of aggressive patients
  - Mixing of civil and forensic patients in same room or unit
  - Mixing patients with neurocognitive and neurodevelopmental disorders with other patients
  - Inadequate staffing
  - Facility deficiencies (building materials that can be used as weapons, shared patient rooms, poor lines of sight)

Findings

Office of the State Inspector General (OSIG) receives hundreds of complaints but independently investigates only a relatively small portion of them.

Many state hospitals' reports of serious patient safety incidents are incomplete, which can prevent necessary review and follow up.

OSIG relies heavily on DHBDS to handle the complaints it receives about state hospitals

- State law requires OSIG to receive and investigate complaints about abuse, neglect, or inadequate patient care at state psychiatric hospitals.
- In practice, OSIG does not independently investigate most complaints it receives
  - In FY23, OSIG reviewed only 117 of 633 complaints it received about DBHDS facilities and referred most back to DBHDS
- Referring complaints to DBHDS was previously identified as a concern by JLARC in 2019

Recommendation 24

The General Assembly may wish to consider directing OSIG to

1) develop and submit a plan to fulfill its statutory obligation to fully investigate complaints received that contain serious allegations of abuse, neglect or inadequate care at any state psychiatric hospital; and
2) report annually on the number of complaints it receives about state psychiatric hospitals and the number fully investigated by OSIG.

Incomplete hospital reports on safety incidents can prevent necessary reviews and follow up

- Oversight entities, including DBHDS central office, OSIG, and dLCV, need reliable and accurate information about patient safety incidents at state hospitals
  - Particularly severe incidents should receive more oversight attention
- State hospitals are not consistently reporting key information necessary to prompt required follow up of patient safety incidents
  - e.g., data indicating the severity of incidents was missing for one-third of incidents reported by CCCA

dLCV = The disAbility Law Center of Virginia

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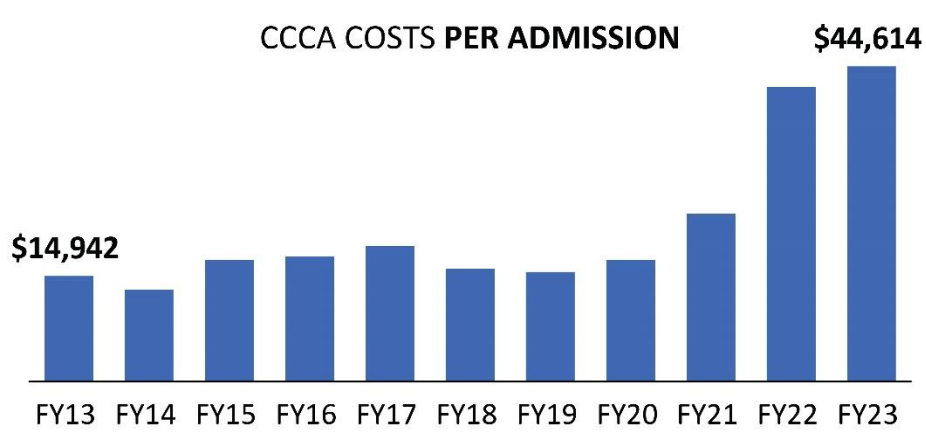
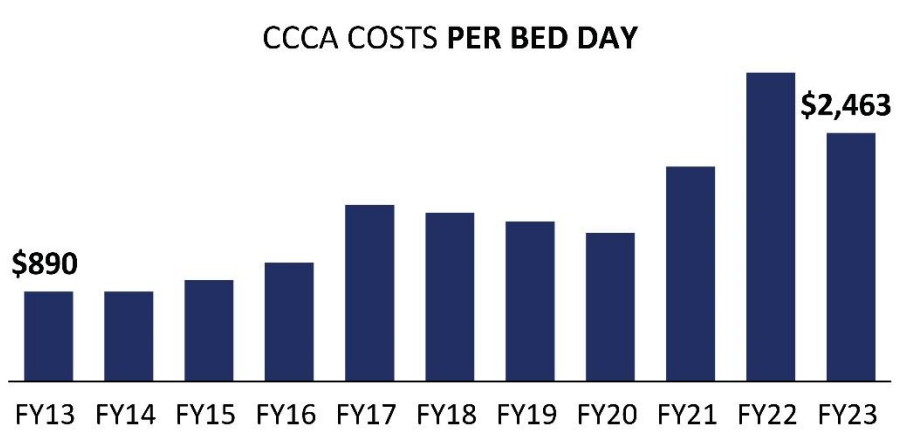
Finding

State psychiatric hospital for children and youth has persistent operational and performance issues, and operational costs have increased substantially.

CCCA costs have increased over the past decade

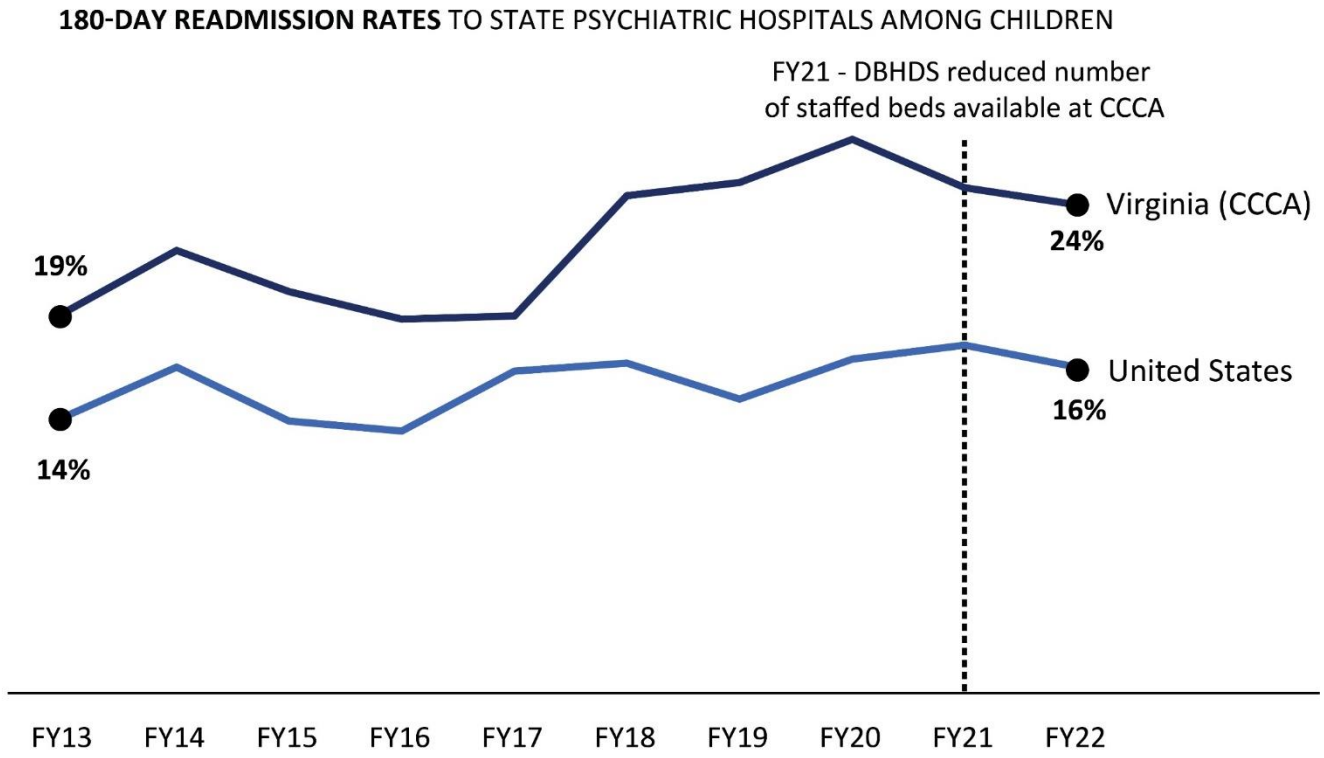
- Total CCCA costs increased from $10.3 million in FY13 to $18.2 million in FY23





Note: Figures adjusted for inflation. CCCA = Commonwealth Center for Children and Adolescents

CCCA readmission rates are higher than national rates



Note: CCCA data is based on state fiscal year. United States data is based on federal fiscal year

CCCA performs poorly on other key metrics relative to all other state hospitals

Metric	CCCA performance	CCCA performance relative to other eight state hospitals
Average annual turnover (FY21 to FY23)	88%	Highest
Vacancy rate (excluding temporary contractors) (June 2023)	43%	Highest
Patient-to-staff physical incident rate	99 incidents per 1,000 patient days	Highest
Patient restraint rates	17.1 hours per 1,000 patient hours	Highest *(40 times the national rate*)*
Patient-to-patient physical incident rate	73.9 per 1,000 patient bed days	Highest
Percentage of human rights complaints that were substantiated	32%	Highest

*Compared with the Joint Commission's national benchmarks for use of restraint among children ages 13—17 at public and private inpatient psychiatric facilities.

DBHDS central office has recently tried to preserve CCCA's accreditation, improve staffing

- In May 2023, CCCA received 28 citations after an unannounced inspection by the Joint Commission, a national accreditation agency
  - CCCA was determined to be an immediate threat to the health and safety of patients, according to DBHDS
- DBHDS central office has taken steps to address operational and performance issues, including leadership changes, on-site hiring assistance, and training changes
- Still, DBHDS reports that CCCA "continues to struggle to meet minimum operating and clinical standards"

Plan should be developed to close CCCA and find or develop alternative placements for youth

- Other states contract with private providers to serve youth who require inpatient mental health treatment
  - Georgia, Louisiana, Tennessee
- Some youth could be more appropriately served in crisis stabilization units or residential treatment centers
- Staffing resources could be reassigned to Western State Hospital, which is 2.5 miles away and experiencing staffing difficulties

Relatively small number of youth would need alternative placements

- CCCA serves relatively few youth (~24 at a time), so the total number of youth needing a bed at a private hospital or another inpatient psychiatric facility (e.g., crisis stabilization unit) would be relatively low
  - Fewer than 2 patients admitted to CCCA per day, on average, between FY21 and FY23
- There are 552 privately operated inpatient psychiatric beds for youth in Virginia, according to DBHDS

Recommendation 32

The General Assembly may wish to consider directing DBHDS to develop a plan to close CCCA and find or develop alternative effective, safe, and therapeutic placements for children and youth who would otherwise be admitted to CCCA.

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