Joint Commission on Health Care
Behavioral Health Care Subcommittee Meeting August 20, 2014

Office of the State Inspector General

June W. Jennings

Over 25 years with the Commonwealth of Virginia

Previously:

- Deputy State Inspector General
- Virginia Department of Corrections Inspector General
- Auditor of Public Accounts Senior Auditor

Certified Public Accountant, Certified Inspector General

Member of:

- Virginia Association of Chiefs of Police
- American Institute of Certified Public Accountants
- Institute of Internal Auditors
- Association of Inspectors General

1

Core Responsibilities

Investigate allegations of fraud, waste, and abuse in management and operations of state agencies and non-state agencies

Administer the State Fraud, Waste, and Abuse Hotline and the Whistleblower Reward Fund

Conduct performance reviews of state agencies to enhance efficiency and effectiveness of Executive Branch agencies

3

Behavioral Health and Developmental Services-Specific Responsibilities

State facility/provider inspections (policy and operational recommendations)
- Announced
- Unannounced

Inspect, monitor, and review quality of care
- State facilities, providers, and treatment units in correctional facilities
- Independent reviews and investigations of complaints

Report incidents
- General Assembly
- Joint Commission on Health Care

Review, comment, and provide recommendations
- Reports prepared by DBHDS
- Critical incident data collected by DBHDS

Monitor, review, and comment on DBHDS-adopted regulations

4

Statutory Authority

Code of Virginia § 2.2-309

5

Office of the State Inspector General Structure

The Office of the State Inspector General's (OSIG) structure resulted from the consolidation of several inspector general functions/audit oversight units within the Commonwealth

- **Virginia Department of Corrections**
- **Office of the Inspector General-Behavioral Health and Developmental Services**
- **Virginia Department of Transportation**
- **Department of Juvenile Justice**
- **Division of State Internal Audit**

6

Office of the State Inspector General Divisions

The Office of the State Inspector General (OSIG) was organized around its statutory responsibilities, which fall into one of four categories below.

- **Performance Review Services Division**
- **Internal Audit Oversight and Training Division**
- **Behavioral Health and Developmental Services Division**
- **Investigative and Law Enforcement Services Division**
  - **State Fraud, Waste, and Abuse Hotline**
  - **Whistle Blower Fund**

7

Behavioral Health and Developmental Services Division Current Activities

Since the beginning of FY2015, the Behavioral Health and Developmental Services (BHDS) Division has completed three reports, with anticipated release in the next six weeks.

A Review of the Application of the Human Rights Regulations in the State-Operated Behavioral Health Facilities

Annual Review of the Virginia Center for Behavioral Rehabilitation

Review of Critical Events: Environmental Safety at the Commonwealth Center for Children and Adolescents

8

A Review of the Application of the Human Rights Regulations in the State-Operated Behavioral Health Facilities

The OSIG conducted unannounced reviews of eight DBHDS adult behavioral health hospitals, one facility for children and adolescents, and one free-standing medical center. The review initiated in February 2014 and concluded in April 2014.

Significant findings

- Policies/procedures and Human Rights Regulations
- Identification of practices for standardization
- Unavailability of secure site database
- Limited secure site database monitoring and accountability procedures

9

Annual Review of the Virginia Center for Behavioral Rehabilitation

Review of Virginia Center for Behavioral Rehabilitation's (VCBR) implementation of the double-bunking process.

Significant findings

- Structured screening process
- Active participation and movement through three-phase treatment program
- Admission and discharge rates
- Increase of opportunities for inappropriate sexual activity
- Untimely discharge for individuals who completed treatment and were granted conditional release

10

Review of Critical Events: Environmental Safety at the Commonwealth Center for Children and Adolescents

Review of Commonwealth Center for Children and Adolescents (CCCA) response to a series of critical events in December 2013 and late January/early February 2014. Three events required local law enforcement involvement.

Significant findings

- Immediate identification and addressing of environmental corrections
- Facility management and direct care staff differing perceptions
- Challenge of mixing forensic and non-forensic patients
- Lack of dedicated facility security staff

11

Additional BHDS Division Activities

- A report of the unannounced inspections at state-operated training centers
- Ten active complaints under investigation
- Ongoing monitoring activities
  - Critical incidents in state facilities, including deaths
  - Autopsies
  - DBHDS Media Alerts
  - State-operated facilities overtime and staff turnover rates

12

BHDS Division Proposed Activities

The BHDS Division will be completing four special studies during FY2015.

Access to Behavioral Health Services in Department of Juvenile Justice Correctional Facilities and Certified Local Detention Centers

Access to Adult Behavioral Health Services by Service Recipients in Virginia's Licensed Assisted Living Facilities

Monitoring Effectiveness of the Psychiatric Bed Registry

Reviewing Implementation of Regional Crisis Protocols for Compliance with State Mental Health Crisis Mandates

13

Report 2014-BHDS-004: Review of Mental Health Services in Local and Regional Jails

14

Review of Mental Health Services in Local and Regional Jails

OSIG Report 2014-BHDS-004: *Review of Mental Health Services in Local and Regional Jails* **includes 24 recommendations.**

Selected recommendations follow. The full report can be accessed online at http://www.osig.virginia.gov/ by clicking on the *Reports* **tab.**

15

Focus of 2014-BHDS-004 Review

The OSIG initiated this review in order to determine how Virginia's jails are addressing the challenges of serving individuals with mental illness.

The examination focused on answering questions concerning policies and practices utilized by Virginia jails for supervising incarcerated individuals with mental illness.

16

Methodology

- Site visits to 25 local and regional jails between July 17, 2013 and September 25, 2013
- Reviewed 172 medical records of incarcerated individuals with mental illness
- Interviewed leadership at all jails visited

17

Selected Findings and Recommendations

Findings

- In FY 2012, Virginia appropriated $184 million in SGF and $11.2 million of federal block grant dollars for community-based mental health treatment, spent an additional $366 million as the state share of Medicaid mental health payments for treatment in the community, and invested $211.7 million in support of state hospital mental health treatment for individuals whose treatment needs could not be met in the community. There are no comparable SGF appropriated to jails for the treatment of individuals with the same behavioral health treatment needs.

  RECOMMENDATION NO. 1-A - Virginia should develop a strategy for funding mental health treatment for individuals in local and regional jails that is proportional to the investment in support services for the same population in the community.

18

Selected Findings and Recommendations (cont.)

Finding

- **Once an individual enters a jail, Medicaid eligibility is terminated and the funding for any current services terminates. Since most community providers rely on Medicaid reimbursement to underwrite mental health, CSBs and other providers frequently have no reimbursement mechanism to serve individuals in jails. The cessation of Medicaid funding and the absence of state funding lead to a breakdown in the continuity of care in the Commonwealth.**

RECOMMENDATION NO. 1-B - The Commonwealth should establish a process for suspending, rather than terminating, Medicaid when individuals enter local and regional jails.

19

Selected Findings and Recommendations (cont.)

Finding

- **Jails reported challenges associated with accessing current or previous mental health treatment information and the reluctance of CSB staff to provide onsite visits.**

RECOMMENDATION NO. 1-D – CSBs and local or regional jails should develop Business Associate Agreements to facilitate the effective exchange of mental health treatment information.

20

Selected Findings and Recommendations (cont.)

FINDING

- The fact that individuals with mental illness are in secure and supervised settings in jails may contribute to delay in transferring these individuals to state hospitals because CSB emergency staff look for imminent risk of harm to self or others and inability to care for self as key criteria for involuntary hospital admission and people in jails are deemed to be "safe."

RECOMMENDATION NO. 3-B - A workgroup consisting of jail medical staff, CSB emergency staff, and DBHDS facility medical staff should develop protocols to guide the pre-admission screening process for individuals with mental illness who are in local and regional jails, focusing on reducing the risk of individuals deteriorating solely as a result of their jail residency.

21

Selected Findings and Recommendations (cont.)

FINDING

- All jails reviewed were designed to house individuals in a manner that maximized safety and ensured the greatest capacity to control inmate movement. The design was consistent with the objectives of a correctional facility, but was not always conducive to addressing the treatment needs of inmates with mental illness, especially the most severe forms of mental illness and those individuals with active psychotic symptoms.

RECOMMENDATION NO. 4-C - Future jail construction and renovations should place greater focus on the safety and treatment needs of mentally ill individuals.

22

Selected Findings and Recommendations (cont.)

Finding

- **Jail designs are consistent with the objectives of a correctional facility, but was not always conducive to addressing the treatment needs of inmates with mental illness, especially the most severe forms of mental illness and those individuals with active psychotic symptoms.**
- **Six of the 25 (25%) jails had established mental health units or pods in order to decrease the isolation of individuals with mental illness and expand opportunities for engagement.**
- **These units were likely to have dedicated staff with additional mental health training and were able to interact more readily, although much of that interaction lacked privacy.**

RECOMMENDATION NO. 4-E - Consideration should be given to the creation of mental health pods in local and regional jails. This would serve to expand active treatment for individuals with mental illness.

23

Selected Findings and Recommendations (cont.)

FINDING

- **Jails in the review were not able to provide information about the rate of recidivism for individuals with mental illness, but staff at each jail commented on numerous "frequent flyers" in their facility. While jail administrators, medical staff, and mental health staff frequently commented on the problem of recidivism, only 39% (9 of 25) of jails had policies with a provision to link the individual with community mental health providers on release.**

RECOMMENDATION NO. 6-A - Jails should develop mechanisms for tracking recidivism of individuals with mental illness that were "engaged" in treatment at time of release.

24

Questions and Answers

25