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Report to the Governor and the General Assembly of Virginia

Virginia's State Psychiatric Hospitals

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JLARC
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

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Summary: Virginia's State Psychiatric Hospitals

WHAT WE FOUND

Virginia's state-run psychiatric hospitals face numerous challenges to effectively treating patients with especially acute psychiatric needs, and one of the greatest challenges is recruiting and retaining staff willing to work in an unpredictable environment that poses personal safety risks daily. The state psychiatric hospital work environment is difficult for nursing and clinical staff, but also the many support staff who are integral to hospital operations. Despite the difficulties inherent in working in such an environment, it is clear that state psychiatric hospital employees are highly committed to providing effective care to patients and providing needed support to their colleagues.

WHY WE DID THIS STUDY

In 2022, the Joint Legislative Audit and Review Commission directed staff to review the inpatient psychiatric hospitals operated by the state.

ABOUT VIRGINIA'S STATE PSYCHIATRIC HOSPITALS

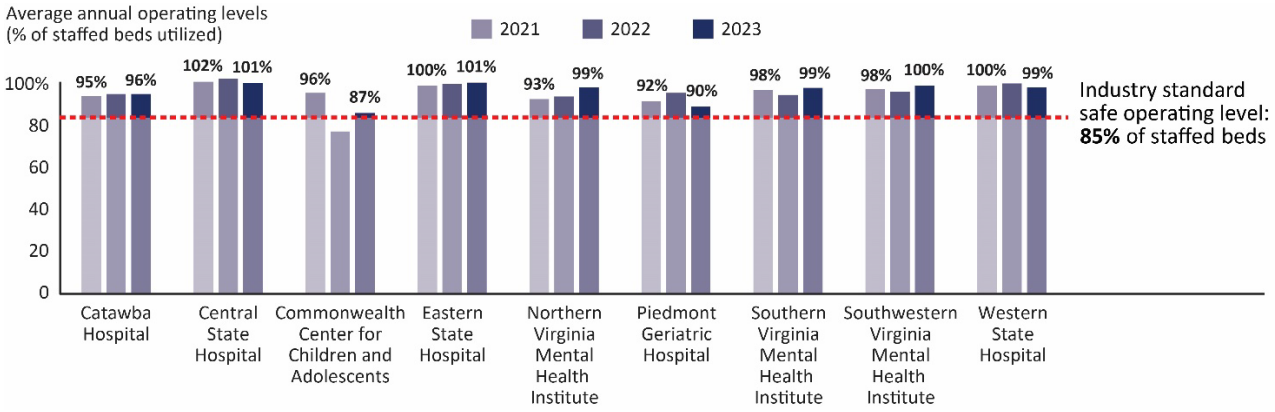
The state operates nine psychiatric hospitals across Virginia, which provide psychiatric treatment services to individuals who are a threat to themselves or others because of mental illness. State hospitals also serve individuals in the criminal justice system, including jail inmates who require inpatient psychiatric treatment and defendants who need inpatient treatment to be able to understand the criminal charges against them. In FY23, about 5,000 individuals were admitted to state psychiatric hospitals, and the largest proportion were under a civil temporary detention order.

State psychiatric hospitals' lack of control over their admissions jeopardizes patient safety

Around half of Virginia's state psychiatric hospital patients are individuals from the community who have been determined to be a threat to themselves or others as a result of a mental illness (i.e, civil patients) and have been admitted involuntarily. Since 2014, state law has required state hospitals to admit individuals who magistrates have placed under a temporary detention order (TDO) if no other placement can be found for them. The legislation was intended to ensure that individuals in need of acute psychiatric services receive treatment, and it removed state hospitals' ability to deny admissions. Since then, state hospitals have experienced significant ongoing capacity constraints and have regularly admitted more patients than they can safely accommodate.

During FY23, seven of the nine state hospitals filled 95 percent or more of their staffed beds, and three regularly filled 100 percent of their beds. According to industry standards, inpatient psychiatric hospitals should not exceed 85 percent of staffed bed capacity to maintain a safe environment. Operating at higher occupancy levels limits hospitals' ability to respond to changing patient needs, such as moving patients to a different room or unit if needed to protect their safety, or protect the safety of other patients and staff, because there is no available extra space. Additionally, being responsible for so many patients limits staff's ability to intervene quickly and effectively in confrontations between patients or between patients and other staff.

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.
NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year.

State hospitals also have seen an increase in inappropriate admissions. If an individual has been determined to meet the criteria for a TDO, but does not actually have a condition that requires psychiatric treatment, statute still requires state hospitals to admit them, which is counterproductive for these individuals' treatment and unsafe for them. These inappropriate admissions include individuals with neurocognitive disorders (i.e., dementia) and neurodevelopmental disorders (i.e., autism spectrum disorder), who accounted for 10 percent of state psychiatric hospital discharges in FY23. While they are a small percentage of state hospital patients, they stay for relatively long periods even though state hospital staff generally do not have the expertise to appropriately care for them. In addition, state psychiatric hospital staff frequently reported concerns regarding the safety and well-being of patients with neurocognitive and neurodevelopmental diagnoses.

Some state hospitals also have seen an increase in individuals who are dropped off by law enforcement before they are admitted, which is unsafe, especially for patients with urgent medical needs. Between FY22 and FY23, law enforcement dropped off 1,432 individuals at state hospitals before they were admitted. Some of these individuals were experiencing urgent medical needs, which state psychiatric hospitals are not equipped to treat. In January 2023, Virginia's attorney general issued an official opinion concluding that law enforcement "dropoffs" at psychiatric hospitals are not permissible under state law. However, more than 450 individuals have been dropped off at state psychiatric hospitals since the issuance of that opinion.

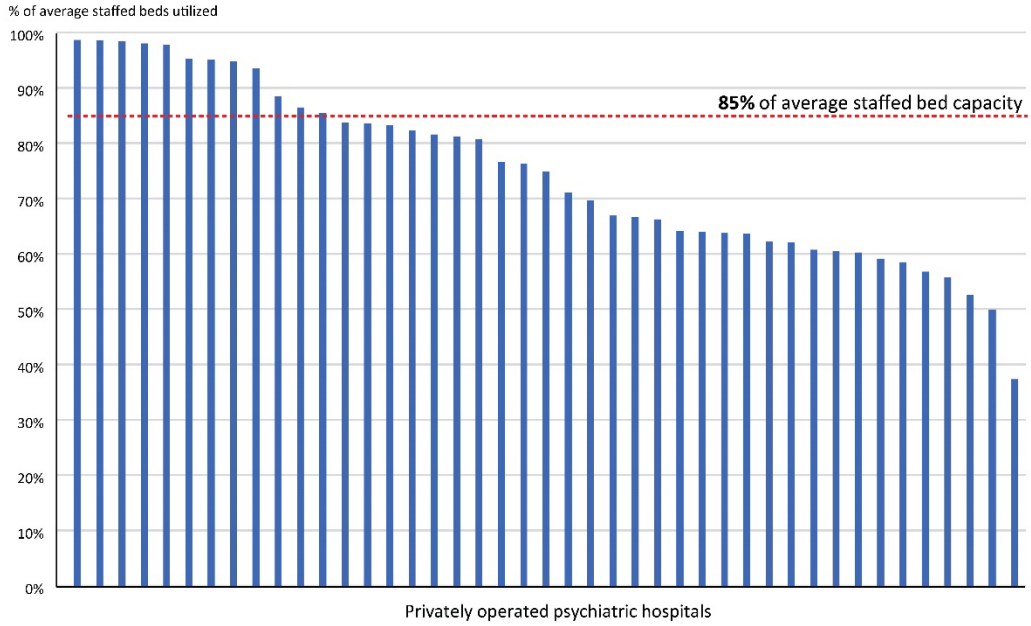
Many private psychiatric hospitals could admit more patients without exceeding safe operating levels

Underutilization of privately operated psychiatric hospital beds places an unnecessary overreliance on state hospitals and can delay or prevent individuals' receipt of needed

treatment. Neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. However, greater utilization of privately operated hospitals would serve a clear public interest and meet a present and growing need to more quickly respond to Virginians who require inpatient psychiatric treatment, reduce the need for law enforcement to wait with patients who need involuntary treatment, and allow state hospitals to operate at safer levels. In FY23, 8,538 individuals under a civil TDO were on a waitlist for admission to a state psychiatric hospital, averaging around 700 individuals per month. Some of these individuals were never admitted to an inpatient facility for further evaluation or treatment, some were dropped off at a state hospital before being accepted by the facility, and some were arrested.

Private psychiatric hospital representatives have previously reported on underutilization of their inpatient psychiatric beds, and the majority of privately operated hospitals operate below the 85 percent staffed capacity level deemed safe for inpatient psychiatric facilities. If private psychiatric hospitals had used a portion of their unused staffed beds in FY22, enough patients would have been diverted from state hospitals to allow both state and private psychiatric hospitals to operate at a safe level.

About two-thirds of private psychiatric hospitals operated below 85 percent of staffed capacity (end of FY22)



SOURCE: JLARC analysis of Virginia Health Information (VHI) data regarding the staffed capacity and patient utilization of private psychiatric hospitals (2022).
NOTE: Four private psychiatric hospitals operated above their average staffed bed capacity. VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Increase in forensic patients has significantly reduced beds available for civil admissions and exacerbated patient and staff safety risks

One reason for the current civil TDO waitlists is the growing number of forensic patients at state hospitals, who are criminal defendants a court has ordered to receive inpatient psychiatric evaluations and/or treatment. Increasing forensic patient admissions have affected all eight state hospitals for adults. Forensic admissions accounted for 47 percent of all admissions to state psychiatric hospitals in FY23. In addition, forensic patients remain hospitalized for about three times longer than civil patients, on average, so increased forensic admissions have substantially reduced state hospital bed capacity for civil admissions, and this trend is expected to continue. Moreover, because the costs of serving forensic patients cannot generally be billed to Medicaid, Medicare, or commercial insurance, growing forensic admissions have increased the state's costs to operate state psychiatric hospitals.

The largest percentage of forensic patients are pre-trial defendants who judges find to be incompetent to stand trial and who must receive services to restore their competency. While many defendants receive outpatient competency restoration services, the majority receive these services on an inpatient basis at the state's psychiatric hospitals. State hospitals have delayed admitting some defendants for competency restoration because of capacity limitations, creating risks that the state will be sued for violating defendants' due process rights, which has happened in at least 16 states. In Virginia, from March through July 2023, 508 defendants were delayed admission to state hospitals for competency restoration. The other categories of forensic patients at state hospitals include individuals in jails or correctional centers who are determined to need inpatient psychiatric treatment under a TDO and individuals found not guilty by reason of insanity.

If state hospitals remain the only inpatient setting for treating forensic patients and no other action is taken to prioritize who is admitted for competency restoration, the capacity pressures they place on state hospitals are likely to worsen. This increasing forensic patient population exacerbates existing staff and patient safety risks because some forensic patients can be especially aggressive, according to state hospital staff. This is particularly concerning in state hospitals that mix civil and forensic patients in the same treatment unit or in the same room.

State hospitals are difficult to staff because of the unsafe working environment and uncompetitive pay for some positions

Statewide turnover across all state hospitals was 30 percent in FY23—over twice as high as the overall state government turnover rate. High turnover rates among state psychiatric hospital staff are a longstanding problem, but turnover has worsened over the past decade. As turnover has increased, positions have become more difficult to fill, leading to higher vacancy rates. The total state hospital staff vacancy rate doubled between June 2013 and June 2022 from 11 percent to 23 percent.

State hospital staff conveyed on a JLARC survey and through interviews that their facilities do not have enough staff to provide adequate care for patients. The majority of nursing and clinical staff responding to a JLARC survey observed their hospitals were insufficiently staffed. Twenty-eight percent of nursing and clinical staff reported that they usually lack enough time to give patients the attention they need, and this was especially common among social workers, case managers, and psychologists.

Virginia does not have specific staffing standards for either its state or privately operated psychiatric hospitals, and there is no industry consensus or federal requirement regarding the ratio of direct care staff to psychiatric hospital patients. A 2022 workgroup composed of chief nurse executives from Virginia state psychiatric hospitals determined a minimum staffing standard for nursing staff, but only one hospital meets that standard, and DBHDS has set a staffing goal below the workgroup's recommendation because of funding constraints.

Most state psychiatric hospitals have increased their use of temporary contract staff to fill vacant positions, raising state hospital operating costs. On a per-staff basis, contractors are much more expensive—between two and three times the cost—than nurses and clinicians employed directly by the facility. In FY23, state hospitals spent at least 9 percent of their operating budget on contract staff ($47 million), 13 times the amount spent in FY13. The amount of total state hospital employee compensation spent on overtime more than tripled over this same time period, from $5.8 million in FY13 to $20 million in FY23. Combined overtime and contracting costs ($67 million) are more than six times higher than the previous decade.

Some state hospital roles are compensated at less-than-competitive rates, but working conditions also contribute to staffing shortages. Positions that were benchmarked to have the least competitive pay compared with the regional median pay were psychologists, social workers, housekeeping staff, and food services staff. While pay increases should be considered, pay is not the only factor making state hospitals difficult to staff. These facilities are some of the most physically dangerous work environments in all of state government; state hospitals have *seven times* the rate of successful workers' compensation claims as employees in other state government agencies.

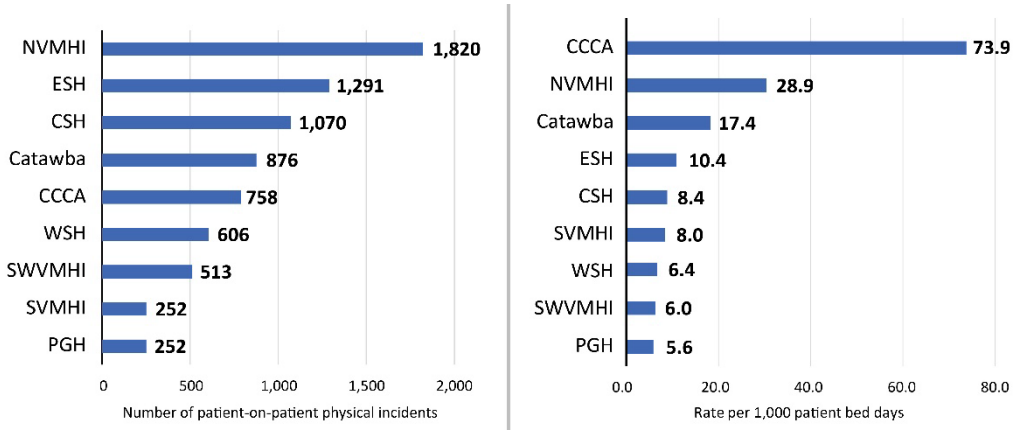
In addition to frustrations with pay and concerns over personal safety, state hospital nursing staff reported dissatisfaction with their hospital's shift schedules. One in four registered nurses who predicted that they would leave their jobs in the next six months cited scheduling as a top reason they were planning to leave. In particular, state hospital leadership and staff expressed frustration with their hospital's inability to offer 12-hour shifts to their employees, which is a standard healthcare industry practice.

Patient safety is a concern, and some Virginia state hospitals use patient seclusion and restraint more often than other states

All hospitals had at least 20 percent of their staff report that they did not believe that their hospital was a safe place for patients, and staff commonly attributed this belief

to high numbers of aggressive patients, increasing numbers of forensic patients, and the admission of patients with neurodevelopmental and neurocognitive disorders. There were about 7,400 known patient-on-patient physical incidents at state hospitals between January 2022 and May 2023 and 1,800 incidents of reported self-injurious behaviors. Across all of these incidents, over 1,400 resulted in patient injuries.

Rates of reported patient-on-patient physical incidents (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS Incident Tracker data and Avatar data.
NOTE: The denominator 'patient bed days' is used to measure incidence rates, because it bases incidence rates on the total number of days that patients received care in their hospital, allowing for comparability of incidents across facilities of various sizes. For example, if a facility has 100 beds and each bed is filled by a patient every day of the year, the facility would have 36,500 bed days that year.

State hospital staffing shortages and facility deficiencies, including weaponizable facility features, complicate state psychiatric hospitals' efforts to maintain a safe environment. Most state psychiatric hospitals were not originally designed as inpatient psychiatric hospitals, and various facility deficiencies contribute to safety incidents and hinder staff's ability to keep patients safe. Examples of facility deficiencies include ceramic tiles that can be removed and used as weapons; features like door handles and hinges that present risks to patients intent on harming themselves; hidden alcoves or poor lines of sight; shared rooms at seven hospitals, with at least two hospitals able to accommodate up to four patients in the same room; and lack of modern response mechanisms at four hospitals, which makes it more difficult for staff to efficiently de-escalate aggressive patient behavior or intervene quickly when patient incidents occur.

The use of seclusion and restraint is particularly high at some hospitals, and staff have reported that they and their colleagues are not well trained on how to properly use these methods or respond to patient aggression. State regulation requires all DBHDS-licensed and operated hospitals to use seclusion and restraint only as a last-resort intervention during an immediate crisis, with limits on the length of time adults and children can be subjected to either. Five of the nine state hospitals used higher rates of *restraint* relative to the national average. Six of the nine state hospitals used *seclusion*

at higher rates than national averages. The Commonwealth Center for Children and Adolescents (CCCA) restrains patients at a higher rate than any other state hospital and over 20 times higher than the reported national average. CCCA patients also generally spend a longer amount of time continuously in restraints compared with other hospitals. DBHDS central office made efforts in 2023 to reduce the use of restraint at the facility, including leadership changes and greater attention to de-escalation methods used by staff.

OSIG receives hundreds of complaints but independently investigates only a relatively small portion of them

State hospital staff have unmatched visibility into patients' care and potential safety risks, including possible violations of their personal safety or human rights. However, state hospital staff do not uniformly feel comfortable reporting patient safety concerns to their supervisor or hospital leadership. An independent complaint investigation process is critical to ensuring that patients, visitors, staff, or others have a safe and non-threatening means to raise concerns and can be confident that the investigation of their complaint will have integrity and lead to the proper resolution. The General Assembly has identified this need and assigned Virginia's Office of the State Inspector General (OSIG) to receive and investigate complaints about patient care and safety at state psychiatric hospitals.

OSIG's approach to handling complaints that it receives does not ensure that complaints are independently or thoroughly investigated, counter to the General Assembly's intent. In FY23, OSIG received 633 complaints about DBHDS facilities, but referred most of them back to DBHDS and state hospitals to investigate. OSIG itself reviewed just 117 of those complaints. Independent investigation of patient safety complaints is essential, because referring complaints made to OSIG back to DBHDS and the hospitals could result in complaints not being investigated thoroughly or, worse, being purposely ignored or concealed. It also makes it less likely that appropriate and effective remedies and sanctions will be pursued.

Independent review of a sample of patient records concluded that most sampled patients received satisfactory care, but there were exceptions

The quality of patient care can affect the likelihood of their readmission to an inpatient setting after discharge. Over the past decade, about one in five adults and one in four children discharged from a state psychiatric hospital under a civil status were readmitted within six months. Psychiatrists at VCU Health conducted an independent review of state hospital patient charts for this study. Psychiatrists collectively concluded that most patients in the sample appeared to have received satisfactory care, but there were exceptions. For example, VCU psychiatrists reported concerns about the medication given to 17 of the 45 patients from the sample who received medications during their

hospitalization, including the dosage, appropriateness of the medication for the patient's diagnosis, or adverse side effects. In several instances, reviewers noted concerns about the use of multiple medications simultaneously. Reviewers also observed little documentation by doctors or psychiatric nurse practitioners about the patient's progress or their visits with the patient.

During JLARC staff's visits to the state psychiatric hospitals, staff at several hospitals pointed out deficiencies in the hospitals' physical space that they believed hindered the hospital's ability to provide optimal patient care and treatment. For example, hospital staff highlighted that in some hospitals, there is not enough space to offer small group therapy sessions as often as needed.

Psychiatric hospital for children and youth has persistent operational and performance issues

CCCA is intended to be the facility of last resort for youth experiencing a severe mental illness and who are a threat to themselves or others. However, persistent operational and performance issues at CCCA justify considering whether CCCA should continue to operate. Through various metrics, CCCA stands out as the worst or among the worst performers compared with other state hospitals. For example, it has the highest rate of patient-on-patient and patient-on-staff physical safety incidents, the highest rate of patient self-harm, the highest number and percentage of substantiated human rights complaints, the highest use of physical restraint against patients, the highest staff turnover, nearly the highest staff vacancy rate, and the greatest dependence on expensive contract staff. In a recent unannounced inspection by a national accrediting agency (the Joint Commission), CCCA received 28 citations and was determined to be an immediate threat to the health and safety of patients, according to DBHDS.

CCCA has become more costly to operate, neither patient outcomes nor staffing challenges have improved, and additional investment in the facility is unlikely to result in further improvements. Additionally, most other states do not operate a youth psychiatric hospital.

DBHDS should develop a plan to close CCCA and find or develop alternative placements for the patients who would otherwise be placed there. Following approaches used in other states, including those that do not operate a state hospital for children, the state should contract for services that would better meet the needs of CCCA patients, including private psychiatric hospitals, residential crisis stabilization units, and residential psychiatric treatment facilities, and that are closer to their home communities. State funds used to operate CCCA, about $18 million in FY23, could instead help fund placements for youth who would otherwise be admitted there. If CCCA were closed, at any given time the number of youth needing an alternative placement, such as at a private psychiatric hospital, a crisis stabilization unit, or residential psychiatric treatment facility, would be relatively low (two youths per day, on average).

WHAT WE RECOMMEND

The following recommendations include only those highlighted for the report summary. The complete list of recommendations is available on page xi.

Legislative action

- Exclude behaviors and symptoms that are solely the manifestation of a neurocognitive or neurodevelopmental disorder from the definition of mental illness for the purposes of TDOs and civil commitments so that they are not a basis for placing an individual under a TDO or involuntarily committing them to an inpatient psychiatric hospital, with an effective date of July 1, 2025.
- Grant state psychiatric hospitals the authority to deny admission to an individual under a TDO or civil commitment if the individual's behaviors are solely a manifestation of a neurocognitive or neurodevelopmental disorder and the individual does not meet the criteria for inpatient psychiatric treatment, with an effective date of July 1, 2025.
- Direct the secretary of health and human resources to evaluate the availability of placements for individuals with neurocognitive or neurodevelopmental disorders and identify and develop strategies to support these populations, including through enhanced Medicaid reimbursements or Medicaid waivers, and report results by October 2024.
- Grant state psychiatric hospitals the authority to delay the admission of an individual until it has been determined that they do not have urgent medical needs that the hospital cannot treat.
- Require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need (COPN) for a project involving an inpatient psychiatric facility on the applicant's agreement to admit individuals who are under a civil TDO.
- Provide funding to assist privately operated hospitals with accepting more individuals under a TDO and with discharging patients who face substantial barriers to discharge.
- Grant state psychiatric hospitals the authority to decline admission to an individual under a TDO if doing so will result in the hospital operating in excess of 85 percent of the hospital's staffed capacity, with an effective date of July 1, 2025.
- Provide salary increases for social workers, psychologists, and housekeeping and food services staff.
- Direct the Department of Human Resource Management to allow state hospitals to define nursing staff who work 36 hours per week as full-time staff to facilitate hospitals' ability to use 12-hour shifts.

- Create and fund the number of nursing positions DBHDS has determined are needed to provide quality care at the state's psychiatric hospitals.
- Direct OSIG to develop and submit a plan to fulfill its statutory obligation to fully investigate complaints of serious allegations of abuse, neglect, or inadequate care at any state psychiatric hospital, and develop and submit annually a report on the number of complaints it has received and fully investigated.
- Direct DBHDS to develop a plan to close CCCA and find or develop alternative placements for children and youth.

Executive action

- Virginia Department of Health should develop and implement a process to determine whether all providers granted a COPN based at least partially on their commitment to accept patients under a TDO are fulfilling this commitment and take appropriate remedial steps to bring them into compliance with this commitment, if necessary.
- DBHDS should seek clarification from the Office of the Attorney General regarding whether the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a TDO or civil commitment if the provider has the capacity to do so safely.
- DBHDS should formally solicit proposals from state-licensed psychiatric hospitals or units in Virginia to admit certain categories of forensic patients and work with those hospitals that respond to develop a plan and timeline to contract with them to admit forensic patients.
- DBHDS should study and propose designating certain state psychiatric hospitals or units within them as appropriate to treat only forensic patients.
- DBHDS should contract with a subject matter expert to assess the therapeutic environment for each state psychiatric hospital, prioritizing those with the highest rates of seclusion and restraint.
- DBHDS should develop and implement a process to conduct regular reviews of a sample of state psychiatric hospital patient records to evaluate the quality of care they provide, including procedures for holding hospitals accountable for correcting factors that are determined to cause the delivery of ineffective, unsafe, or generally substandard patient care.

3 Civil Admissions to Private Hospitals

Privately operated, state-licensed psychiatric hospitals ("private psychiatric hospitals") play an integral role in Virginia's overall behavioral health system and treatment of individuals needing inpatient treatment (sidebar). In FY22, 49,350 adults were discharged from a private psychiatric hospital in Virginia—about 10 times as many as the number of people discharged from state hospitals in the same year (~5,000). CSB staff must attempt to place individuals under a temporary detention order (TDO) in private psychiatric hospitals before placing them in a state psychiatric hospital, and the best available data indicates that the majority of patients under a civil TDO are served by a private hospital (sidebar, next page).

For simplicity, this report will refer to all non-state operated psychiatric hospitals as **"privately operated hospitals."** These are freestanding psychiatric hospitals and psychiatric units in general hospitals that are licensed by DBHDS to provide inpatient psychiatric care. These include teaching hospitals that receive public funding for their operations (e.g., University of Virginia Medical Center), but that are not state-operated facilities.

According to data maintained by Virginia Health Information (VHI) and the Department of Behavioral Health and Developmental Services (DBHDS), Virginia has approximately 1,660 adult and 550 youth inpatient beds across 47 private psychiatric hospitals. These beds account for just over half of Virginia's total adult inpatient bed capacity and almost all of its youth bed capacity.

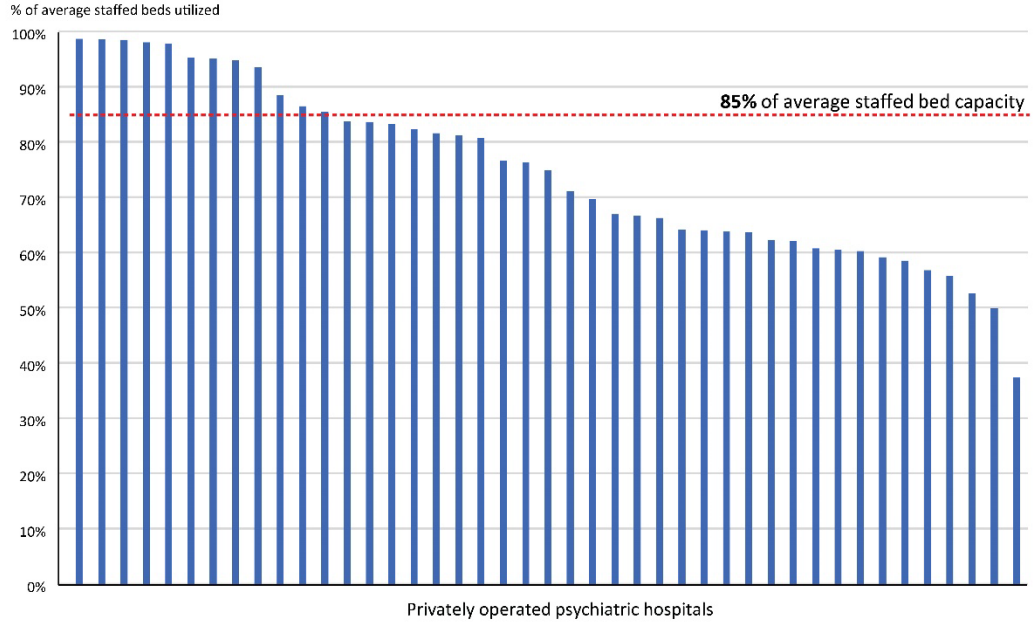
Designating state hospitals as the safety net providers through the Bed of Last Resort law appears to have unintentionally allowed service providers to be more selective in who they admit and avoid admitting, treating, and managing the needs of some Virginians in need of inpatient treatment. Selectivity on the part of many providers has resulted in state psychiatric hospitals being required to admit individuals who could have been served by privately operated hospitals. This is evidenced by excess staffed bed capacity in some privately operated psychiatric hospitals.

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

While state hospitals have been operating at or near their staffed capacity, the majority of adult private psychiatric hospitals operate below their staffed capacity (Figure 3-1). Adult state psychiatric hospitals have consistently operated at a median of 99 percent of their staffed capacity on a given day between July 2021 and October 2023. Several of these hospitals operated between 100 and 102 percent of their total staffed capacity during this period. According to the most recent available VHI data, 31 of the 43 private psychiatric hospitals for adults used less than 85 percent of their average staffed bed capacity in 2022, which is the industry standard for a safe operating level (sidebar). Many of the hospitals operated far below that level. In the 31 hospitals that operated below 85 percent of staffed capacity, a substantial number of additional inpatient bed days—67,884—could have been used before the hospitals reached 85 percent of staffed capacity.

Information on **private psychiatric hospital beds for children and adolescents** is also reported to VHI but includes residential psychiatric placements. Therefore, a similar analysis to the one presented in this chapter for youth beds is not possible.

FIGURE 3-1
About two-thirds of adult private psychiatric hospitals operated below 85 percent of staffed capacity (FY22)



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals (FY22).
NOTE: VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Private psychiatric hospital beds' underutilization has previously been reported by representatives of these facilities. In 2019, the Virginia Hospital and Healthcare Association (VHHA) surveyed its members and reported that 46 percent of private psychiatric hospitals operated below 85 percent of their staffed capacity.

The number of *unused staffed beds* at adult private psychiatric hospitals increased 38 percent between FY14 and FY22. Some of this increase could at least partially be explained by reduced admissions during the COVID-19 pandemic. However, the largest increase in the number of unused beds occurred around the implementation of the Bed of Last Resort law in 2014 (Figure 3-2).

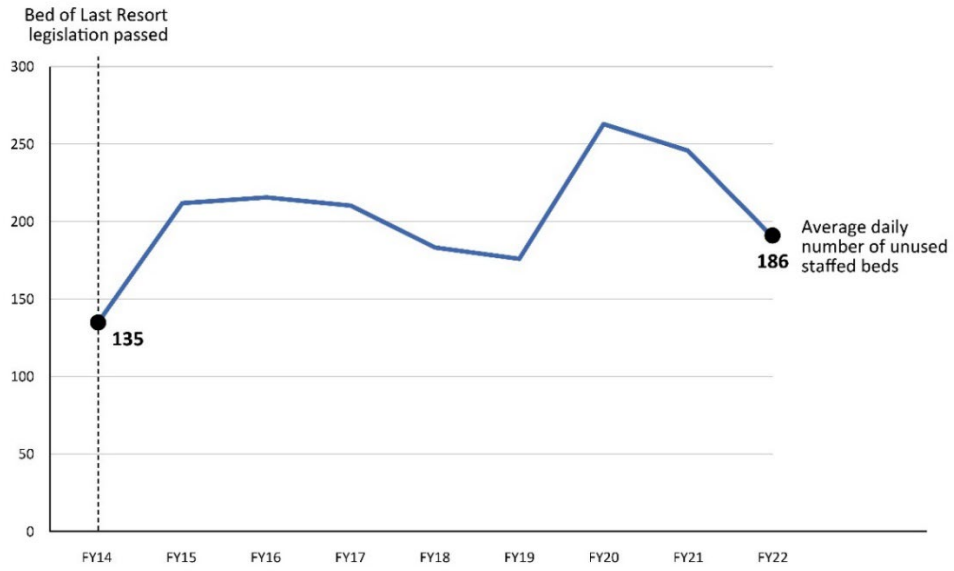
If adult private psychiatric hospitals had used around half of these unused beds in FY22, enough patients would have been diverted from adult state hospitals to allow them to operate at a safe capacity level. If an additional 32,266 bed days in private hospitals had been used to treat adult patients who were ultimately admitted to state hospitals in FY22, state hospitals could have operated at 85 percent of their capacity. At the same time, adult private hospitals would have continued to operate below 85 percent of their average staffed capacity (sidebar). (This analysis assumes that these additional bed days were distributed across all of the adult private psychiatric hospitals that were operating under 85 percent of their staffed bed capacity, Figure 3-3.)

Previous reports to the General Assembly on TDO admissions to private psychiatric hospitals overstated the admissions because the admission figures assumed that any TDO patient not admitted to a state hospital was admitted to a private hospital, but some of those not admitted to a state hospital were never admitted to any inpatient setting.

In the third quarter of FY22, **VHI began tracking the TDO status of individuals** discharged from private psychiatric hospitals. This data could provide more accurate information on the number of TDO patients admitted to private hospitals than is currently being reported.

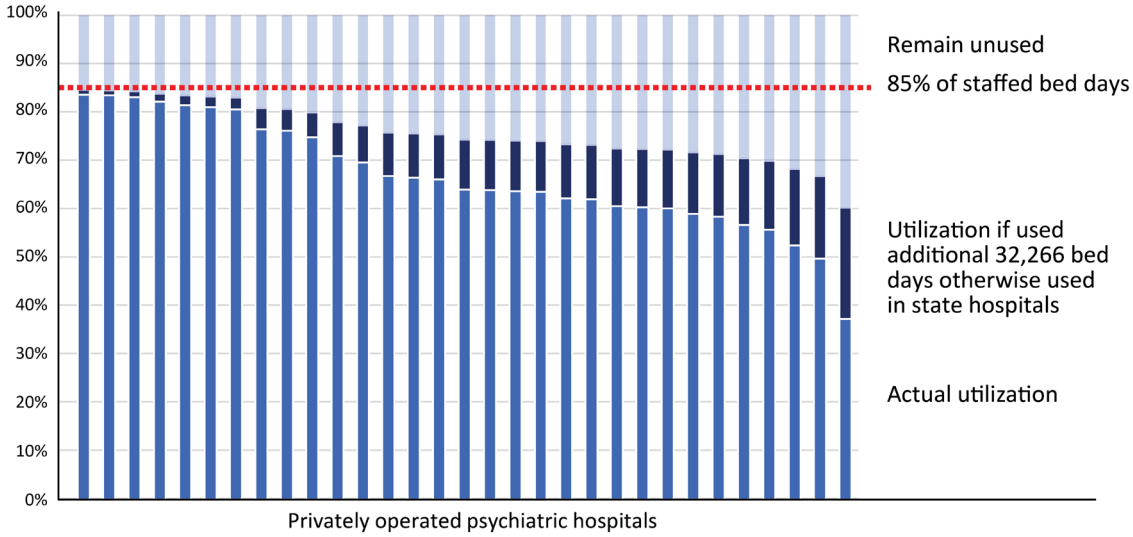
Fewer adult private hospital beds than JLARC's estimates may be needed for state hospitals to operate at safer levels. Reducing forensic admissions to state hospitals and preventing inappropriate TDOs would both increase state hospitals' capacity to accept civil patients and reduce the number of individuals needing temporary detention. (More discussion in Chapters 2 and 4.)

FIGURE 3-2
The statewide average number of unused staffed beds in adult private psychiatric hospitals has increased over time



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals.
NOTE: Only unused beds that were within 85 percent of the facilities' average staffed bed capacity were counted in this estimate. Additional unused beds exist. See Appendix B for more details.

FIGURE 3-3
Distributing additional bed days across adult private psychiatric hospitals operating below 85 percent capacity would have allowed them to continue operating within safe levels (FY22)



SOURCE: JLARC analysis of VHI data.
NOTE: Additional bed days were distributed across facilities based on the proportion of total unused staffed bed days statewide that they accounted for. Unused staffed bed days included only unused beds that were within 85 percent of a facility's total operating capacity. Thirty-one facilities had unused staffed bed days within 85 percent of their average staffed bed capacity. The fiscal year for each privately operated psychiatric hospital may vary.

This increase in adult private hospital utilization would have had a large positive impact on state hospitals' operations while allowing the private hospitals to continue to operate at safe levels. Many of the challenges discussed throughout this report—safety concerns, staff burnout and turnover, and discharge pressures—stem from high utilization and admission pressures placed on state hospitals.

Private psychiatric hospitals are justifiably concerned about risks that high-need patients create for staff and patient safety

Regardless of funding, general concerns regarding the safety of patients and staff will continue to affect private psychiatric hospitals' willingness or ability to accept additional patients for involuntary admissions. Private psychiatric hospital staff indicated that safety risks to their staff are a key consideration when considering whether to admit additional patients, and some indicated that they felt ill-equipped to protect their staff from especially aggressive or volatile patients.

Private psychiatric hospitals could take several steps to improve their ability to protect their staff from more aggressive and volatile patients. Additional security staff, staff training, and facility improvements were all resources that private hospital staff reported they would need to accept more patients under TDOs or civil commitments. State funding to help cover these costs could incentivize these hospitals to accept more civil TDOs and civil commitments, even if the hospitals could afford to do so without financial incentives. The state already reimburses private hospitals for taking some uninsured patients who would have been admitted to state hospitals from the Local Inpatient Purchase of Services (LIPOS) fund. In FY22, the state allocated around $8.8 million from this fund to cover the costs of serving 993 individuals in private hospitals.

RECOMMENDATION 7

The General Assembly may wish to consider including language and funding in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to establish a program for state-licensed psychiatric hospitals (commonly referred to as "private psychiatric hospitals") to provide funding for those hospitals that agree to increase the percentage of involuntary inpatient admissions they accept and demonstrate the need for funding to safely admit such patients. Funds could be provided to cover one-time and ongoing costs for creating and filling additional security positions, providing staff training on how to safely treat these patients, and making safety improvements to the facilities.

Another approach to incentivizing private hospitals to accept more involuntary admissions would be to provide higher Medicaid reimbursements for involuntary patients. Medicaid is an increasingly important source of revenue for private hospitals; in FY21 (most recent data available), a median of 42 percent of each hospital's patients were enrolled in Medicaid, more than double the proportion in FY18. Policymakers could also explore making eligibility for Medicaid reimbursement contingent on private hospitals' increasing the number of involuntary admissions by a certain amount, but the

permissibility of this approach would need to be reviewed by the Centers for Medicare and Medicaid Services (CMS).

Insufficient funding to support patient discharges from psychiatric hospitals deters private hospitals from admitting certain patients

Various stakeholders indicated that individuals who are likely to face barriers to discharge, including individuals with longer stays and complex conditions, were commonly placed on state hospital civil admission waitlists. One of the most common reasons private psychiatric hospitals reported for denying admission to patients needing involuntary treatment was concern with patients that are challenging to discharge.

Patients who are difficult to discharge cost hospitals more because commercial insurers, Medicaid, and Medicare do not reimburse the costs of their stays after they have been determined to no longer need inpatient treatment. Additionally, hospitals tend to spend more staff time and other resources locating appropriate discharge placements for these patients.

The General Assembly allocates funding to DBHDS for post-discharge services and support for patients in state hospitals who are difficult to discharge through the Discharge Assistance Program (DAP). DAP funding is used to (1) assist with the costs of post-discharge services and placements and (2) develop new post-discharge services and placements when none are available for patients in state psychiatric hospitals who face barriers to discharge. DAP funding is used for supports and services such as in-home services, transportation, medications, and placements in nursing homes, assisted-living facilities, and other less intensive facilities.

In contrast, discharge assistance funding has not been available for patients in private psychiatric hospitals, and these hospitals have been requesting access to these funds to help discharge individuals in a timely manner and reduce the costs of securing post-discharge services and placements for difficult-to-discharge patients. Without access to discharge assistance funding, private hospitals are disincentivized from accepting patients who may be challenging to discharge because they must absorb the cost to arrange the discharge and the cost of the portion of the inpatient stay that extends beyond what is determined to be clinically necessary. In its FY25–26 operating budget request, DBHDS has asked that private psychiatric hospitals have access to available discharge assistance funds.

Allowing discharge assistance funding to support discharges from private psychiatric hospitals could help ensure that they are not disincentivized from admitting patients that they believe will be challenging to discharge.

RECOMMENDATION 8

The General Assembly may wish to consider including language and funding in the Appropriation Act to expand the discharge assistance provided by the Department of Behavioral Health and Developmental Services (DBHDS) to individuals facing substantial barriers to discharge from inpatient psychiatric units and facilities licensed by DBHDS (commonly referred to as "privately operated").

Underutilization of private hospital beds places avoidable burdens on patients, law enforcement, and state hospitals

In FY23, 8,538 individuals under a TDO experienced delays receiving needed psychiatric treatment after they had been deemed an imminent risk to themselves or others because no private psychiatric hospital bed was found for them, and a state hospital bed was not immediately available. Of those individuals, *at least*

- 235 were never admitted to an inpatient facility for further evaluation or treatment—instances the Bed of Last Resort law was intended to prevent;
- 927 were dropped off at a state hospital before being accepted by the facility; and
- 36 were arrested before an inpatient bed was secured because of incidents that occurred while waiting for a bed.

The underutilization of private hospital capacity also prolongs law enforcement officers' involvement in TDO cases and unnecessarily occupies emergency department beds.

The underutilization of private psychiatric hospitals is at least partially due to a reluctance by these facilities to serve certain populations. Current and former leadership and staff of private psychiatric hospitals reported knowing that some *other* privately operated facilities in Virginia do not admit patients they *could* treat. For example, individuals with potential barriers to future discharge were commonly reported to be denied admission to private psychiatric hospitals.

The Bed of Last Resort law likely exacerbates the overreliance on state hospitals to provide inpatient care to individuals needing involuntary psychiatric treatment because it requires state hospitals to accept any individual under a TDO if another placement cannot be secured. The Bed of Last Resort law requires other placements to be sought first, and so its intent is to avoid the use of state psychiatric hospitals unless absolutely necessary. However, neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. Multiple national subject matter experts raised concerns that the existing law places undue pressure on Virginia's state psychiatric hospitals because it allows private psychiatric hospitals to be selective in their admissions.

Hospitals are already required to treat individuals in emergencies if they have the capability to do so. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), a hospital is required to treat individuals who need to be stabilized because of an emergency medical condition, either on an inpatient or outpatient basis, when a hospital has the staff and physical capacity to do so. The federal definition of "emergency medical condition" includes individuals experiencing "psychiatric disturbances" that, without immediate attention, "could reasonably be expected to result in placing the health of the individual...in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." This definition includes individuals who are substantially likely to be an imminent risk to themselves because of mental illness—one of the three circumstances by which an individual may meet the criteria for involuntary psychiatric treatment in Virginia. At least in some circumstances, private hospitals that do not admit TDO patients whom they have the ability to treat into their psychiatric units would be in violation of EMTALA.

State could use the certificate of public need process to ensure that privately operated hospitals accept TDO patients

State law requires that healthcare providers receive a certificate of public need (COPN) from the state health commissioner before undertaking a project to establish, expand, or relocate certain types of medical facilities, including inpatient psychiatric facilities or units within general hospitals. Most states (35), including Virginia, operate a COPN process, and the general purposes of such a process are to control costs by avoiding unnecessary expansion or duplication of services in an area and to improve access to underserved areas or populations.

To receive a COPN in Virginia, a healthcare provider must demonstrate through an application process that the proposed project meets a public need, according to criteria specified in state law. State law also requires the state health commissioner to condition the approval of any COPN on the applicant's agreement to meet certain conditions. These conditions include "to provide a specified level of charity care to indigent persons" or to "accept patients requiring specialized care." If the COPN is issued, the provider must meet those conditions annually or be subject to a civil penalty. Furthermore, when a provider applies for a COPN to operate psychiatric inpatient beds, state regulations require the Virginia Department of Health to give preference to proposals "demonstrating a willingness to accept persons under a temporary detention order."

State law does not specify who should be considered "patients requiring specialized care" in the COPN process.

In their COPN application, some private psychiatric hospitals have committed to accepting TDO patients. Between January 2021 and September 2022, the state health commissioner granted approval to nine projects seeking to add inpatient psychiatric beds, and in four of them, the approval was partially based on the applicant's commitment to accepting TDO patients.

To improve access to inpatient care for TDO patients, the state health commissioner should develop and implement a process to ensure that providers who have committed in their COPN application to serve TDO patients are fulfilling this commitment. If

providers are found not to be meeting their commitment to serve TDO patients, the commissioner, using the authority granted in state law, should take appropriate steps to bring the provider into compliance. State law authorizes the commissioner to impose civil penalties if providers refuse, fail, or neglect to honor agreed-upon conditions.

The VHI, which reports to the Virginia Department of Health, now collects information to identify the number and proportion of patients admitted to each hospital who were under a TDO at the time of admission. The Virginia Department of Health should use this information as part of its review process to determine the extent to which hospitals are meeting their commitments.

RECOMMENDATION 9

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

The General Assembly should establish in state law that providers must agree to accept TDO patients as a condition of *future* COPN approvals related to inpatient psychiatric beds. This change would apply to projects seeking to open a new inpatient psychiatric hospital or add inpatient psychiatric beds to an existing facility. State law already has a precedent for requiring a COPN applicant to commit to serving certain categories of patients (i.e., providing charity care or serving individuals who require specialized care), and accepting patients under a TDO follows this precedent.

RECOMMENDATION 10

The General Assembly may wish to consider amending § 32.1-102.4 of the Code of Virginia to require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need for a project involving an inpatient psychiatric service or facility on the agreement of the applicant to accept patients under a temporary detention order whenever the provider has the capacity and capability to do so.

Because the previous two recommendations would only affect *new inpatient psychiatric beds* or *providers that previously committed to serving TDOs*, the General Assembly could consider and evaluate other options to require existing inpatient facilities to accept patients under a TDO, even if they did not previously commit to doing so as part of their COPN application. For example, the General Assembly could consider requiring that projects seeking to expand inpatient psychiatric services only be considered by the Virginia Department of Health commissioner if either they (1) previously agreed to accept TDO patients in their prior COPN application(s) or (2) agree to accept TDO

patients in at least some of their existing facilities going forward. However, these legislative changes and their impacts would need to be further evaluated and may not be necessary if DBHDS already has the authority to require providers to accept TDO patients, as described below.

DBHDS may already have the authority to require that private psychiatric hospitals serve TDO patients

Another option that the executive branch could consider to help patients under a TDO receive the care they need and alleviate pressures on emergency rooms, law enforcement officers, and state hospitals is for the DBHDS commissioner to use existing authority granted to him under state provider licensure requirements. DBHDS licenses providers of inpatient psychiatric services, including private psychiatric hospitals and psychiatric units within general hospitals, and state regulations authorize the DBHDS commissioner to impose additional requirements on licensed providers:

> The commissioner may add stipulations on a license issued to a provider…to impose additional requirements on the provider *(12VAC35-105-50.B)*

Because DBHDS-issued licenses must be renewed at least once every three years, DBHDS could potentially use this authority to prohibit licensed providers from denying admission to an individual under a TDO when the provider is operating below 85 percent of staffed capacity. Exceptions could be allowed when a provider demonstrates that accepting the individual would jeopardize the individual's safety or the provider's ability to care for their existing patients. DBHDS has the authority to implement sanctions for non-compliance, including issuing fees, prohibiting new admissions, and reducing the licensed capacity of a facility.

Such a requirement would be consistent with the expectations under EMTALA, which specify that hospitals should not deny admission to patients experiencing an emergency condition if they have the capability and capacity to treat them.

Massachusetts has used its licensing authority to take such action. The Massachusetts Department of Mental Health specifies in its licensing regulations that privately operated psychiatric hospitals, which are licensed by the department, cannot deny admission of involuntary patients when they have the capability and capacity to treat them. This provision was promulgated to address the recurring problem of involuntarily detained mental health patients spending protracted amounts of time in emergency rooms waiting to be admitted to an inpatient unit or facility for mental health treatment. The requirement is consistent with EMTALA's requirements, according to Massachusetts department staff. Staff reported that the provision has helped increase the rate at which private hospitals admit involuntary patients, including those with more challenging conditions and behaviors.

Because DBHDS licensure regulations are generally related to patients who are receiving services through licensed providers (rather than those who *could* be receiving services), DBHDS should seek clarification from the Office of the Attorney General

about this authority. If the Office of the Attorney General determines that the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to accept TDO patients if they can do so safely, then the commissioner should use this authority and develop and implement processes to ensure compliance with it.

RECOMMENDATION 11

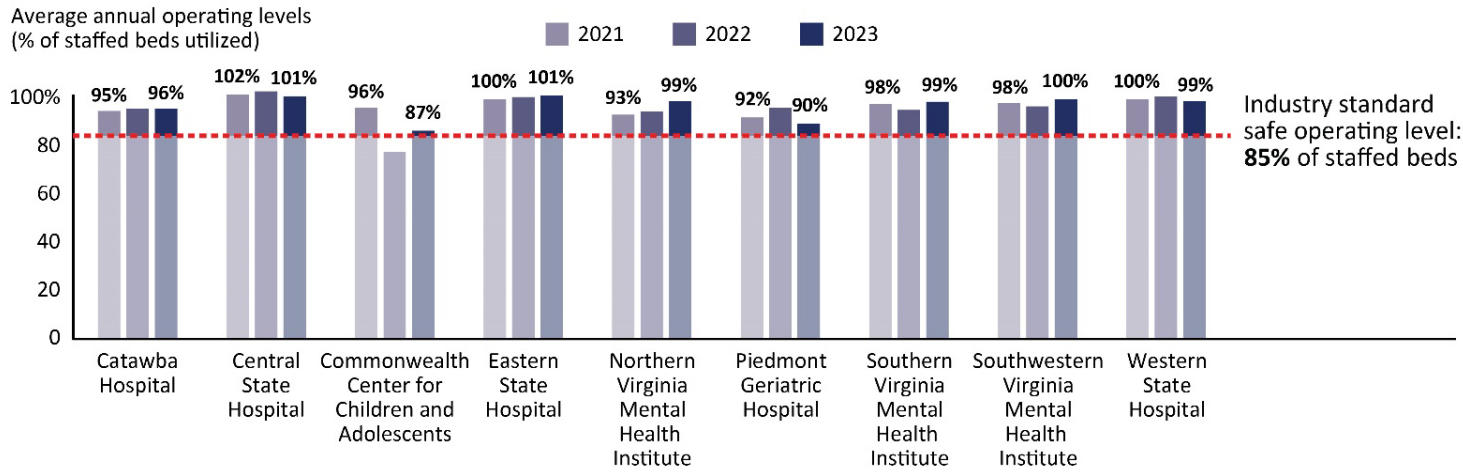
The Department of Behavioral Health and Developmental Services (DBHDS) should seek clarification from the Office of the Attorney General regarding whether the commissioner of DBHDS has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a temporary detention order or civil commitment order if the provider has the capacity to do so safely.

State hospitals should be given the authority to deny admissions based on their staffed capacity

In recent years, all state hospitals have been operating above 85 percent of their staffed bed capacity, and several have regularly exceeded their staffed bed capacity. During 2023, seven state hospitals had an average annual operating level of at least 95 percent of staffed beds, and three regularly filled all their staffed beds (Figure 3-4).

FIGURE 3-4

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.

NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year. Information on staffed beds was available from July 2021 through October 2023.

Operating at these high levels limits the facilities' ability to respond to changing patient needs, in terms of providing appropriate bed placements, treatment, and staff supervision. As expected, DBHDS and state hospital staff reported that it has had detrimental impacts on staffing, the safety of patients and staff, and the quality of care provided—concerns discussed in more detail throughout this report:

> Unsafe staffing conditions are exacerbated when we are forced to go over census. This is a significant risk for staff and patients and ultimately a risk for the system overall. It seems like just a matter of time until a related sentinel event occurs somewhere in the system. (state hospital staff)

> Having a hospital at 100 percent capacity for several years on end is not sustainable; results in poor care, unsafe working conditions, and staff leaving. (state hospital staff)

> The admissions policy that requires this facility to take in more clients regardless of our facility's ability (or lack thereof) due to staffing and bed availability, is not only dangerous for all involved but sends a clear message to the employees that they are not important or valued. Something has to give! People are frustrated and many are getting hurt or worse. (state hospital staff)

State psychiatric hospitals should have the ability to deny civil admissions, at least temporarily, if they are operating at levels that are generally considered unsafe. However, state hospitals currently have no authority to deny admission for civil patients under state law:

> Under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention… unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual for temporary detention

This is much more prescriptive than the regulatory admissions requirements for privately operated psychiatric hospitals, which shall only admit individuals "for which staffing levels and types meet the needs of the individuals receiving services." Providing similar flexibility for state psychiatric hospitals is necessary to improve the safety of these facilities and the ability of staff to properly care for patients.

Two equally important goals should guide efforts to provide needed treatment for Virginians placed under TDOs: ensure that the hospitals offer an environment that is as safe and therapeutic as possible *and* ensure that all Virginians who meet TDO criteria and need inpatient psychiatric treatment are placed, without delay, in an appropriate inpatient setting. To achieve the first goal, state psychiatric hospitals should have the statutory authority to pause new admissions when they are operating at 85 percent of their staffed capacity. However, doing this alone will increase the risk that individuals experiencing a mental health crisis will not receive needed inpatient care (although this already occurs because of civil admission waitlists and the expiration of TDOs before treatment can be provided.) Therefore, DBHDS and the General Assembly should also follow the recommendations provided earlier in this chapter to expand access to other existing inpatient beds in privately operated psychiatric hospitals.

Virginia also needs to build out new community-based resources, like crisis receiving centers that can accept TDO patients, which the General Assembly, DBHDS, and community services boards have already begun to do. However, this cannot be the sole strategy for helping Virginians experiencing a mental health crisis because it will take time and significant financial resources. Further utilizing state-licensed privately operated hospitals with unused capacity can help in the near term to provide more Virginians placed under TDOs with timely care.

Allowing state hospitals to deny involuntary admissions based on their staffed capacity is an essential component of ensuring that state hospitals can provide environments that are safe and therapeutic for patients and safe and more predictable for staff. (See Chapters 5 and 6 for further discussion of patient and staff safety.) However, it is prudent to give the state time to prepare for this change and allow state officials and other stakeholders to take steps to avoid unintended consequences. For example, waitlists for admissions to inpatient facilities, which are already a concern, could grow if other resources for patient treatment are not identified or developed. Therefore, if legislation is enacted to grant state hospitals the authority to deny admission to individuals under a TDO when they reach 85 percent of their staffed capacity, its effective date should be delayed by the General Assembly until 2025.

RECOMMENDATION 12

The General Assembly may wish to consider amending the Code of Virginia to grant state psychiatric hospitals the authority to decline to admit any individual under a temporary detention order if doing so will result in the hospital operating in excess of 85 percent of its total staffed capacity. The legislation's effective date should be delayed until July 1, 2025.