Assessing Quality and Effectiveness in Services: The Virginia Office of the Inspector General

NRI Conference
February 11-13, 2008

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OIG Scope of Oversight

- OIG responsible for oversight of:
  - State operated MH and MR facilities operated by DMHMRSAS (1999)
  - Licensed public & private providers (2001)
    - Local community services boards
    - Private community providers
    - Hospitals with psychiatric units
    - MH units at state prisons
  - Other similar or related entities

OIG Role

- OIG established in Va. Code to:
  - Inspect, monitor and review the quality of services
  - Make policy and operational recommendations to prevent problems, abuses and deficiencies in and improve the effectiveness of programs and services
  - Inform and make recommendations to Governor & General Assembly
  - Conduct such additional investigations and make such reports relating to the administration of the programs and services as are, in the judgment of the IG, necessary or desirable.

System of Oversight in Virginia

- DMHMRSAS Human Rights
- DMHMRSAS Licensure
- DMHMRSAS Internal Investigation
- Medicaid reviews (state/federal)
- National Accreditation
- Virginia Office of Protection & Advocacy
- Office of the Inspector General

Uniqueness of the OIG

- Primary responsibility is to focus on Quality of Care
- Code establishes few limitations on work
- Scope of oversight includes all providers
- OIG reports directly to Governor
- OIG findings/recommendations are made directly to Governor and General Assembly

Mission of OIG

It is the mission of the OIG to serve as a catalyst for improving the quality, effectiveness and efficiency of services for people whose lives are affected by mental illness, mental retardation, and substance abuse

Vision for OIG

- Work of the OIG will result in:
  - Clearer understanding of system, greater transparency
  - Problem solving, learning, & continual improvement
- And will be:
  - Valued by providers
  - Basis for decisions/policy development
  - Source of info. for recipients and families

OIG Organizational Values

- Consumer focused and inclusive
- Quality processes and services
- Integrity
- Mutual support and teamwork
- Respect
- Creativity

Focus of OIG Work

- Investigation of complaints or incidents
- Various monitoring activities:
  – Critical incidents in state facilities
  – Review all deaths/autopsies at facilities
  – Wide range of statistical data
  – DMHMRSAS documents, policies, instructions
- Inspections/reviews

Types of Inspections/Reviews

- Inspection of single facility or program
- Systemic Review that focuses on multiple facilities or programs
  - All state facilities of the same type
  - All community services boards (CMHCs)
  - All providers of a specific services
- Follow-up inspection or review to assess progress toward recommendations

Major Systemic Reviews Since 2005

- CSB Emergency Services **
- Residential Services for Adults with MR
- CSB MH Case Management for Adults **
- CSB SA Outpatient Services for Adults
- Recovery Experience of Individuals in State Hospitals **
- Self-Determination Experience of Individuals in State Training Centers
- CSB Child & Adolescent Services (in process)
- Investigation of VA Tech Incident **

Methodology - Input

- Literature search
- Service recipients and families
- Advocacy groups
- Mental Health Planning Council
- Providers:
  - CSB directors and program directors
  - State facility leadership
  - Private provider representatives
- DMHMRSAS central office
- Other stakeholders

Methodology – General Approach

- Objectivity
- Knowledge-based (services, disability, system)
- Knowledge-based (research principles/methodology)
- Descriptive, not hypothesis-testing
- Inductive – observe facts, form conclusions
- Not Deductive – no hypotheses or theories to test

Methodology - Ethics

- Voluntary participation
- No harm or risk to subjects
- Open design, instruments, data, analyses
- Anonymous
- Not disruptive of treatment
- Person centered, person driven
- Consumer participation in design and administration

Methodology - Design

- Non-experimental
- Survey research
- Descriptive only – no inferential analysis
- No application of treatment
- No random assignment of subjects
- No control groups

Methodology – Research Questions

- Begin with questions/strengths developed from input sources.
  - How many served? What is the array of services in communities? Are services based on goals of the person served? What are the caseloads? What is the wait time to service? What do stakeholders think of the services?
- How does one measure quality in X service?
- Develop quality measures – 5-10, with 20-30 indicators, from literature and input to OIG
- Try to have a question (usually more than one) on each quality measure and indicator.

Methodology – Design Development

- Select methods that let us ask and answer each question or demonstrate each quality measure most directly
  - (e.g., ask persons served, interview staff, review records, announced/unannounced, observe activities/environment)
- Develop instruments or find existing ones that ask the questions.
- Test/refine instrument validity and reliability with focus group (e.g., one CSB's service, thereafter excluded from review)
- Train inspectors

Methodology - Sampling

- Establish sample size – start with highest standard, reduce sample size as resources require – but know where we are with probability, bias, compromises.
- If we have list of persons served, select using good random techniques
- If impractical, sample on site ("delegated sampling", technique for choosing observations)
- Stratified or proportional quota when necessary

Methodology

- Instruments
  - Structured interviews – open ended and closed
  - Structured observations with rating scales
  - Self administered questionnaires
- Methods
  - FTF interviews
  - Record reviews
  - Group administered questionnaires
  - Group discussions
  - Web based surveys
  - Observation of environment/activities
  - Telephone interviews
  - Analysis of available data

Methodology

- Issues with service recipient interviews/ peer inspectors
  - Literacy, availability, language, mental status, cognitive levels, communication techniques, willingness to participate, protection of privacy, accessibility, attention span, relevance of dialogue, length of dialogue, interruption of treatment or chosen activity, reimbursement, time to learn to understand person's communication methods, etc.

Methodology – Data Analysis

- Descriptive data only – univariate, not inferential
  - Frequency distribution - %, rank order, content analysis
  - Measures of central tendency: mean, median, not yet mode
  - Measures of dispersion – standard deviation, only once, then using scale/method from published study.
  - No correlations, yet

Methodology – Write Up

- Use tables, text to present data as simply and briefly as possible
- In OIG reports, where there are **Findings** (conclusions made by the IG) and **Recommendations** (by the IG), data may be arrayed in support of the finding.
- Publish full description of methodology
- Publish instruments

Review of Community Services Board Emergency Services Programs

Emergency Services Quality Statements

- Mission and operational values set direction
- Guided by clear policies and procedures
- Competent staff
- Services are accessible 24/7
- Comprehensive array of services available
- Sound, least restrictive intervention with choice
- Treatment fosters consumers feeling safe, treated with dignity and confidentiality protected
- Systems to monitor and improve effectiveness
- Emergency services complement other services

Indicators of Quality - Example

- #4 - Emergency services, including crisis intervention & prescreening available at all times and easily accessible in timely fashion
  - Accessible 24 hours/365 days
  - Phone numbers widely publicized
  - Toll free access to emergency services
  - Callers reach live person with few transactions
  - Special communication needs well met
  - Staff trained re: crisis intervention & mental illness

Components of the Review

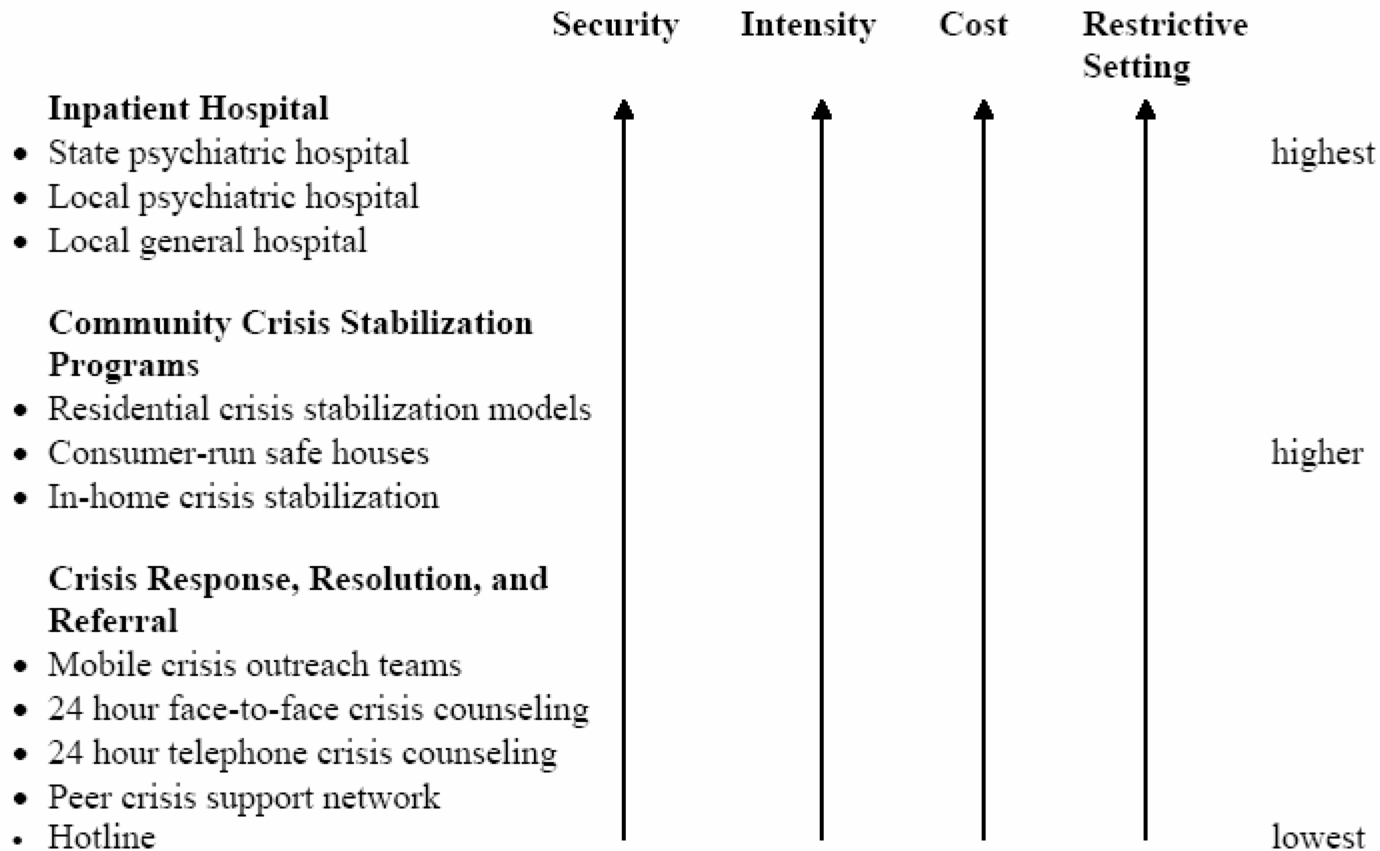
- Survey of service availability (40)
- Unannounced responsiveness tests (40)
- Unannounced field inspections (18)
  - Observed services delivery
  - Interviewed leadership/staff (122), consumers (246) and stakeholders (78)
  - Reviewed records (140)

Inspection Team

- Project Manager – Senior Inspector
- Other OIG inspectors and administrative staff
- Contract inspectors
- Recipients of service

ESP Access Finding #1

The majority of CSBs do not provide a comprehensive range of crisis intervention services. Almost all provide the least restrictive and most restrictive services but very few offer the mid-range Community Crisis Stabilization Programs that can effectively respond to difficult crises in the community. As a result, many consumers are denied effective treatment in the least restrictive setting and dependence on costly inpatient care is greater


Comprehensive Array of Crisis Intervention Services
Security
Intensity
Cost
Restrictive Setting
Inpatient Hospital
State psychiatric hospital
Local psychiatric hospital
Local general hospital
Community Crisis Stabilization Programs
Residential crisis stabilization models
Consumer-run safe houses
In-home crisis stabilization
Crisis Response, Resolution, and Referral
Mobile crisis outreach teams
24 hour face-to-face crisis counseling
24 hour telephone crisis counseling
Peer crisis support network
Hotline
highest
higher
lowest

Office of the Inspector General
Study of CSB Emergency Services

Crisis Intervention Services Continuum (Shaded items indicate community services not widely available)	# of CSBs Offering Service 24/7
Inpatient Hospital	
State hospital facility – State hospitals operated by DMHMRSAS	40
CSB hospital bed purchase - Contracted acute inpatient services in private hospital, often closer to home community; CSB involvement in admission, discharge, and treatment coordination more accessible.	35
Community Crisis Stabilization Programs	
Residential crisis stabilization (TDO) - Like the service below, but licensed to accept TDOs, with 24 hour nursing on site, M.D. daily and on-call for assessments and interventions. All of the current crisis stabilization programs are considering accepting TDOs.	2
Residential crisis stabilization service (voluntary) - 24 hour, CSB-operated or contracted, group home model, available in emergencies, sufficient staffing ratios to provide intensive supports to persons in crisis. Includes nursing on site and MD consultation/visits. (This model of crisis stabilization is currently used in three communities. The General Assembly funded seven additional programs 2005.)	9**
In-Home residential support service – CSB staff goes to the consumer's home and provide supports during crises, keep consumer safe and occupied. Level of support is matched to consumer need. Consumer-focused, not program-focused	6*
Consumer-run residential support service - "Safe house" program. CSB/consumer partnership agreement – many consumers prefer to be served by other consumers in a crisis.	2
Crisis Response, Resolution, and Referral	
Mobile outreach crisis team - Off site, face-to-face. ES clinicians go out to assess and serve persons in crisis wherever they may be, e.g., at consumer's home, on the streets, etc. Not just to hospitals, jails, etc.	9*
Psychiatric evaluation and medication administration. Face-to-face crisis medication evaluation and treatment. MD sees consumer, prescribes or administers meds, 24 hours a day.	1
Psychiatric crisis consultation – Telephone medication consultation with ES clinician or consumer; refill, change, call in prescription, etc. – routine, available by policy, not occasional exception.	12*
Face-to-face crisis counseling – immediate, 24 hours - With CSB ES clinician, without ECO or prescreening requirement. Crisis counseling to resolve or reduce crisis, therapeutic, talk as long as required to address consumer needs.	27
Face-to-face crisis counseling – guaranteed next day with CSB ES staff – Crisis intervention and treatment, may follow contract for safety (not an intake or referral for possible outpatient appointment)	27
Crisis consultation with CSB program (e.g., residential) – For current CSB consumer. ES staff contact the program staff who know the consumer and involve them in stabilizing the crisis, arranging for collaborative intervention, adapting program to address current needs, etc.	30
Telephone crisis counseling - extended - With CSB ES clinician. Crisis counseling on the phone, therapeutic intent, an effort to defuse crisis, provide crisis intervention.	39
Telephone crisis contact - brief - With CSB ES clinician. Initial screening, decision about whether to screen face-to-face, information and referral, assurance about medications, contract for CSB appointment	40
Hotline - a service where consumers can call and talk about their problems and be heard, at length if necessary. Staffed with volunteers, including consumers. Supervised and sponsored by CSB.	11

Unavailability of Community Crisis Stabilization Programs

- Only 3 residential crisis stabilization programs currently. 2005 GA action will add 8 programs
- 65% of staff and 51% of consumers said need more inpatient. However, when asked about impact of more crisis stabilization, all said would help limit demand for inpatient.
- Safety net access to state hospitals is not consistent across commonwealth

Recommendations - Community Crisis Stabilization

- DMHMRSAS/CSBs study
  - Identify/define alternative crisis stabilization services
  - Determine which services to provide state-wide
  - Quantify number and cost of each type service
- Based on results of study:
  - CSBs/regions seek ways to redirect resources
  - DMHMRSAS request sufficient resources
- Based on projected impact, DMHMRSAS & stakeholders determine need for inpatient services
- DMHMRSAS develop expectations for access to state hospital acute beds and admission procedure

ESP Access Finding #2

While the majority of CSB's offer the less intensive Crisis Response, Resolution and Referral Services, capacity limitations restrict service effectiveness, especially in rural areas.

Capacity Problems - Crisis Response, Resolution and Referral Services

- Vast majority of CSBs do not have adequate psychiatric coverage
- Only 9 CSBs offer routine mobile services to homes or street - more go out on limited basis to jail, hospital, etc.
- 40% of stakeholders say experienced or heard about delays

Capacity Problems - Crisis Response, Resolution and Referral Services

- Only 8 CSBs have staff in office 24 hrs/day
- 28 CSBs use answering service or 911 after hours
- 33 CSBs offer toll free crisis access
- Special communication needs generally met
- 68% of consumers say have "quick" access to crisis services

Access by Telephone Crisis Intervention Services

Length of Wait	Day	Night
1 minute or less	14	6
1 to 2 minutes	12	0
2 to 5 minutes	4	8
5 to 15 minutes	4	14
15+ minutes	5	12
No response	1	0

Recommendations – Crisis Response, Resolution & Referral

- DMHMRSAS provide leadership to initiative that will enable sharing of psychiatric resources between facilities and CSBs
- Each CSB routinely monitor time for telephone and face-to-face access to crisis clinician
- DHMRSAS request funding to expand capacity and fill gaps
  - Psychiatric time increased
  - Wait time for access decreased
  - Greater mobility of emergency services

ESP Access Finding #3

Most communities do not have access to appropriate crisis intervention services for consumers with mental retardation. In addition, the role of state hospitals and training centers to serve these consumers is not clear. Result: 1) consumers and staff are placed in dangerous situations & 2) consumers are referred to services that are not appropriate.

Recommendations – Crisis Intervention for Persons with Mental Retardation

- DMHMRSAS study with providers and experts:
  - Identify and define continuum of crisis services for persons with mental retardation
  - Determine which services to provide state-wide
  - Quantify number and cost of each type service
  - Based on study, DMHMRSAS recommend solutions and request funding
- DMHMRSAS establish statewide policy to clarify role of Training Centers and State Hospitals in serving those in crisis

Impact of ESP Review

- State CSB Association established special committee to plan and track CSB responses
- Continuum grid established baseline for tracking service availability statewide
- Crisis stabilization funding expanded by General Assembly last couple of years
- Crisis services included in DMHMRSAS guidelines for use of new transformation funds
- DMHMRSAS directed regional consortia of CSBs/state hospitals to plan for MR crises

Review of the Recovery Experience of Individuals Served at DMHMRSAS Operated Mental Health Facilities

A New Goal for Virginia

Fully implement self-determination, empowerment, recovery, resilience and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR, or SA services.

Starting with the State Hospitals

- State hospitals are operated and funded by DMHMRSAS and present most direct opportunity to advance the recovery vision
- Treatment at state hospital often continues to influence care for the rest of person’s life
- State hospital setting has many features that are antithetical to principles of recovery

Definition of Recovery SAMHSA Consensus Statement on MH Recovery

- Self-Determination
- Individualized & Person-Centered
- Empowerment
- Holistic
- Non-Linear
- Strengths-Based
- Peer Support
- Respect
- Responsibility
- Hope

Review Process – Record Reviews

- Reviewed 309 clinical records
- Examined:
  - Do treatment goals express person's goals & preferences?
  - Degree of person's involvement in treatment plan?
  - What degree of choice granted?
  - Relevant involvement of family and advocates?
  - Use of recovery language and principles?
  - Focus on whole person?

Review Process – Interviews

- Interviewed 309 service recipients
  - 15 questions based on recovery principles
    - Available choices?
    - Degree to which guide own treatment?
    - What has helped most and least?
  - 18 questions from ROSI
- Interviewed 582 staff
- Interviewed 8 facility executive teams

Review Process
Observations & Survey

- Observed:
  - Residential units – 70 (100%)
  - PSR classes - 91
  - Treatment team sessions – 40 (unannounced)
- Used observation checklists based on factors related to recovery principles
- Surveyed all hospital regarding resident involvement

Findings

- Treatment Planning Through Partnership
- Choice
- Involvement in Valued Roles
- Relationships that Support Recovery
- Providing a Supportive Environment for Recovery

Recommendations

- That each MH facility develop and implement a Comprehensive Facility Plan on Recovery. The purpose of this plan will be to enhance the extent to which the experience of those individuals who are served reflects the principles of recovery, self-determination, person-centered planning and choice.

Recommendations

- The plan should identify specific measures to assess progress, be completed no later than August 30, 2007, and address:
  - The role of senior leadership
  - Workforce development
  - Treatment planning
  - Design of the clinical record
  - Resident activities and opportunities
  - Relationship to the community
  - Other areas determined to be relevant

Recommendations

- That each facility prepare a semiannual report that provides an update on progress toward all aspects of the Comprehensive Facility Plan on Recovery and that this report be submitted to the OIG no later than the end of February and August of each year in 2008 and 2009.

Impact of Recovery Review

- All eight recovery plans have been prepared and approved by the OIG
- Include target dates
- Each plan will be published on the hospital website for access by:
  - Individuals being served
  - Families
  - Staff
  - Community service agencies

Investigation of VA Tech Critical Incident & Related Survey Of Community Services Board Mental Health Outpatient Services Capacity

Investigation

- Purpose – formulate recommendations to improve response of community and MH system to individuals experiencing psychiatric emergency
- On-site May 24 and 25 and extensive follow up through June 9
- Primary focus - Services provided in connection with December 2005 temporary detention (TDO):
  - Local CSB
  - Psychiatric unit of local hospital
  - University counseling center

Focus of Investigation

- Examined compliance with requirements of VA Code re: TDO & commitment process
- Identified factors that may have supported or hindered success at each step of process
- Looked at procedural & systemic factors that enable or impede judge's access to information
- Identified factors that may have supported or impeded successful compliance with judge's order

Organization of Findings & Recommendations

- Availability of willing detention facility
- Collection and presentation of evidence and testimony to the judge or special justice
- Outpatient commitment
- Availability and access to services
  - Outpatient services
  - Case management

Outpatient Survey Background

- VA Tech investigation
  - New River Valley CSB, local hospital & Tech counseling center reported lack of outpatient treatment capacity
    - Consistent with earlier OIG reviews
  - New River Valley CSB routine practice of not attending commitment hearings

Survey Background

- Conducted week of June 4, 2007
- 100% response rate
- Focused on CSB:
  - Outpatient treatment wait time
  - Outpatient treatment capacity for adults and children/adolescents (clinicians & psychiatrists)

CSB Average Wait Time for MH Outpatient Services

	Adults (days)	**Children (days)**
Clinician Regular Apptmt	30.22	37.42
Clinician - Apptmt After Emergency	13.54	16.50
Psychiatrist Regular Apptmt	28.16	30.36
Psychiatrist – Apptmt After Emergency	13.54	15.46

CSB Outpatient Staff FTEs Per 50,000 Population

Staff FTEs per 50,000 pop	Adults	Child/Adoles.
0 FTEs No Service	2 (5%)	1 (2.5%)
.01 to 1 FTEs	11 (27.5%)	11 (27.5%)
1.01 to 2 FTEs	12 (30%)	22 (55%)
2.01 to 3 FTEs	6 (15%)	4 (10%)
3.01 to 4.00	3 (7.5%)	2 (5%)
4.01+	6 (15%)	

Change in CSB OP Capacity Over Past 10 Years

	Adults #/% of CSBs	**Child/Adoles. #/ of CSBs**
Increased capacity	6 (15%)	16 (40%)
Decreased Capacity	24 (60%)	20 (50%)
No Change	10 (25%)	4 (10%)

Impact of OP Survey

- Used as baseline information by Supreme Court Commission on MH Law Reform looking at outpatient commitment
- Information used by staff of House and Senate committees to education General Assembly regarding service gaps
- Used as basis for Governor's budget request

Review of
Community Services Board Mental Health Case Management Services for Adults

Case Mgt Quality Statements

- Consumer-centered and consumer-driven
- Coordinates needed services in comprehensive and efficient manner
- Guided by recovery model - principle means for consumer to plan and implement own recovery
- Constructive, helping relationship shared by consumers and case manager that fosters trust, cooperation and support for recovery
- Active, positive service that reaches out to consumers and provides active supports
- Staff - qualified, prepared, supported in their roles

Methodology and Scope

- Surveyed CSBs for basic information
- On-site visit to all 40 CSB's in March
- Interviewed 654 (2.73%) of 23,948 service recipients state-wide:
  - 335 interviewed by 35 peer consumers
  - 319 interviewed by OIG staff

Methodology and Scope

- Interviewed 310 (36.7%) of 845 case managers state-wide
- Interviewed 83 division directors and supervisors (2/CSB)
- Reviewed 403 case records (10/CSB) – 90 days of activity
- Excluded PACT service recipients and case managers

Number Receiving Case Management and Medicaid

Persons with SMI served by CSBs statewide	37,392
Persons with SMI receiving case management statewide	23,948 (64% of persons with SMI)
Percent receiving case mgt on Medicaid statewide	52%
Percent receiving case mgt on Medicaid by CSB	Low of 9% High of 95%

Models and Protocols

Dedicated CM teams	36 CSBs (90%)
Multifunctional Teams	4 CSBs (10%)
Dedicated and Multifunctional Teams	5 CSBs
Caseload limits/caps	13 CSBs
Waiting list protocols	8 CSBs

Consumer-Centered Services Findings

- Consumers and Case Mgr's agree that consumers have significant role in developing their own service plans, however, records fail to reflect this
- Case Mgt recipients have limited opportunity to exercise choice in selection of case managers

Consumer-Driven Service Plans

	Consumer Response	CM Response	CM Records
1. Case Mgr develops the plan	32%	14%	63%
2. Case Mgr invites consumer input to the plan	50%	75%	34%
3. Consumer leads development of the plan	19%	11%	3%

Indicators of Choice/Empowerment

Activity	Percent Who Have Opportunity	Percent Rated as Important
Opportunity to Select Case Mgr	29%	74%
Opportunity to change Case Mgr	56%	80%

Consumer-Centered Services Recommendations

- DMHMRSAS, with DMAS, CSBs and consumers, develop a model case mgt planning system and format that is person-centered, reflects principles of recovery, and meets regulatory requirements
- CSBs review case mgt service delivery methods to identify ways in which consumers can exercise greater choice as recipients of service

Case Management Activity and Outreach Findings

- The frequency of face-to-face contact by CSB case managers with consumers is significantly higher than the minimum requirements of Medicaid
- The location where case managers visit consumers is split fairly evenly between home/community and office based settings

Activity and Location

- Face-to-face visits average 5/90 days:
  - Low CSB – 1.9
  - High CSB – 11.6
- Location split between office/community:
  - 49% - case managers' office
  - 43% - consumers' homes/in community
  - 7% - clubhouse or other day program

Case Management Activity and Outreach Findings

- Average caseload sizes are higher than national standards and higher than case mgr's, supervisors and consumers think is appropriate to ensure highest quality services

Caseload Size

- Average caseload of fulltime CM is 39
- Caseloads reported by CSBs:
  - Low CSB – 20
  - High CSB – 71
- 61% of case managers say caseloads are too large
- Leading suggestion from CM, supervisors and consumers is that more CM are needed
- CSBs report that 235 additional case managers are needed

Case Management Activity and Outreach Recommendations

- DMHMRSAS study the advisability of establishing a caseload standard for CSB case managers who work with individuals with serious mental illness and establish standard if determined advisable
- DMHMRSAS seek resources to increase the number of case mgrs in order to lower the average caseload

Impact of Case Mgt Review

- CSBs have reviewed and revised mission statements to include focus on recovery, person-centered
- DMHMRSAS developed initiative to develop person-centered planning methodology
- Governor and General Assembly are using data about caseload size and basis for budget proposals

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